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# The OHIO STATE MEDICAL Journal

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Published By The Ohio State Medical Association



Viewed through the skyline of the Columbus Civic Center is the Veterans Memorial Building (top of picture) where much of the scientific program of the OSMA 1962 Annual Meeting will be staged. For more details on the Annual Meeting, see pages 71-73.

*Turn to Inside Front Cover for Index*

NUARY 1962
IME 58 ★ NUMBER 1

The
OHIO STATE MEDICAL
Journal

VOL. 58 JANUARY, 1962 NO. 1

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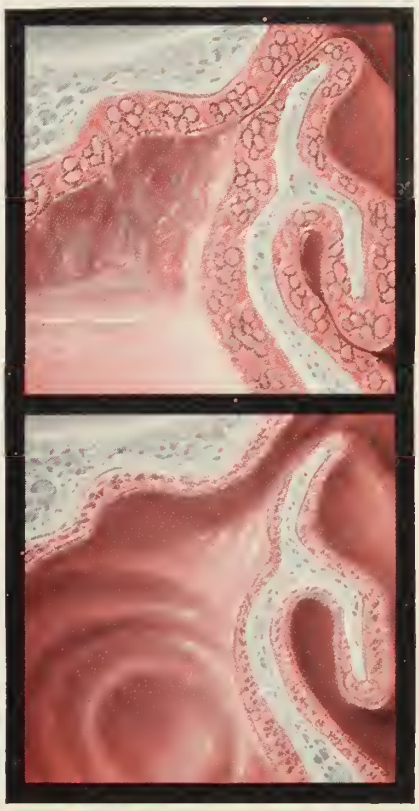
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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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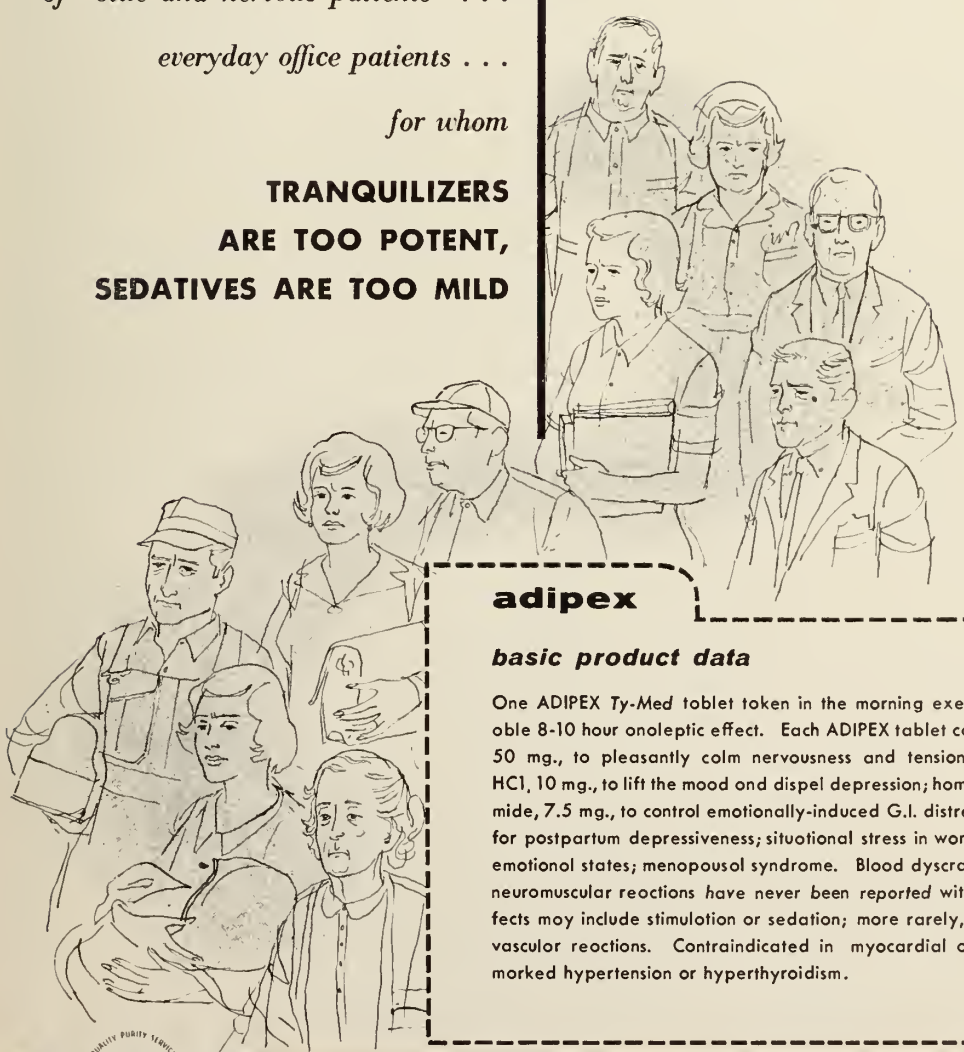
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*References:* 1. Curran, T. R., and Phelps, D. K.: Am. Pract. & Dig. Treat. *11:* 617, 1960. 2. Levy, S.: J.A.M.A. *153:* 1260, 1953. 3. Connolly, R.: W. Va. Med. J. *56:* 263, 1960.



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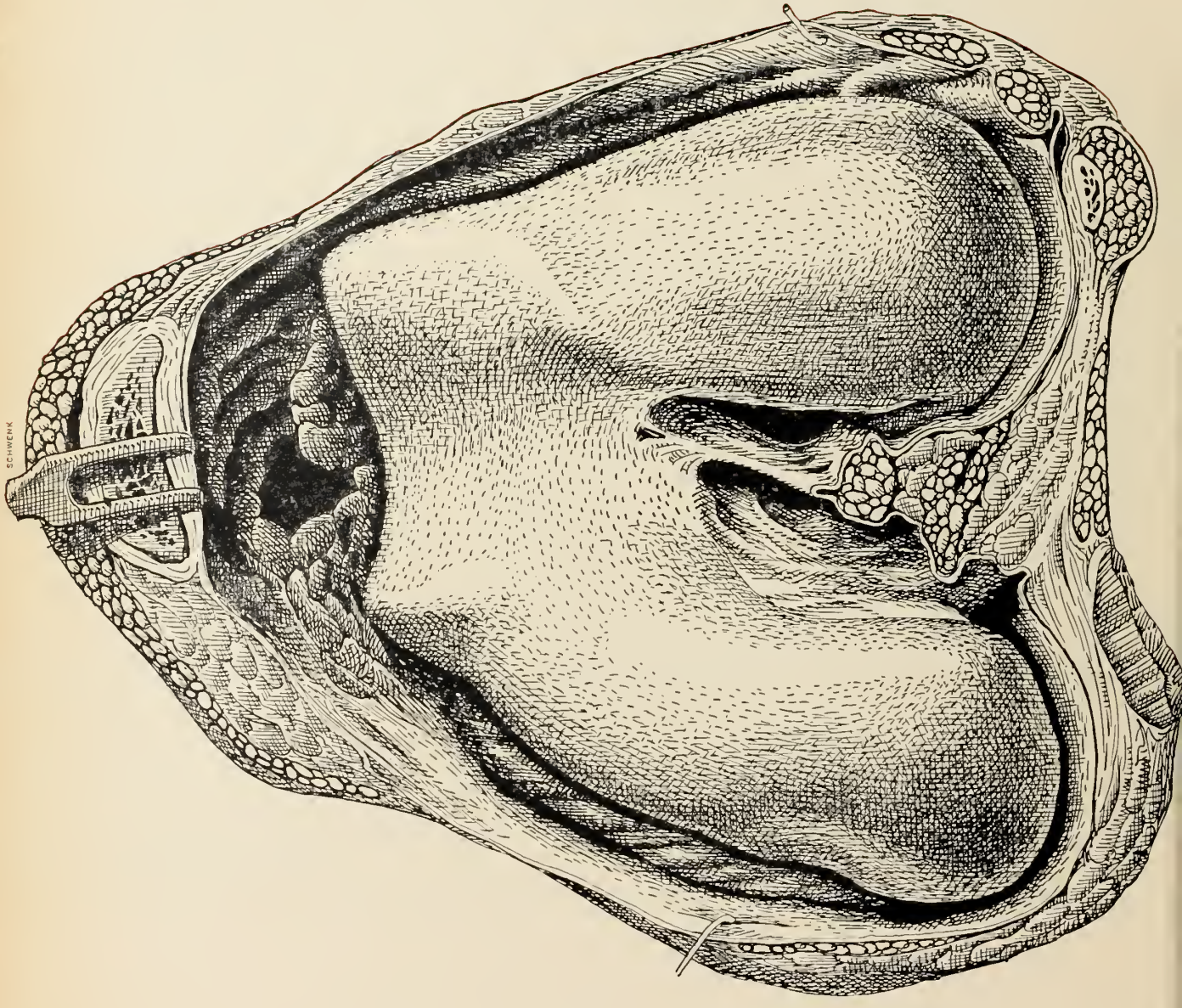
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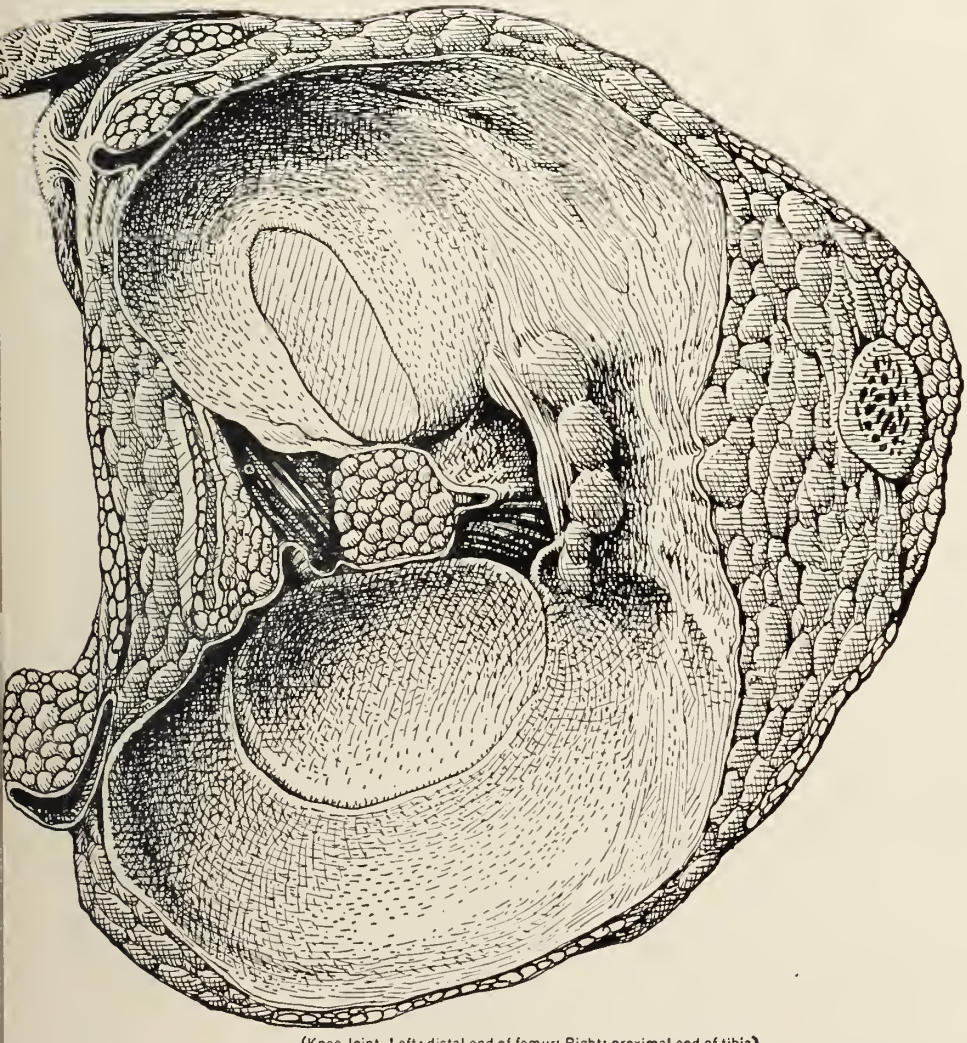
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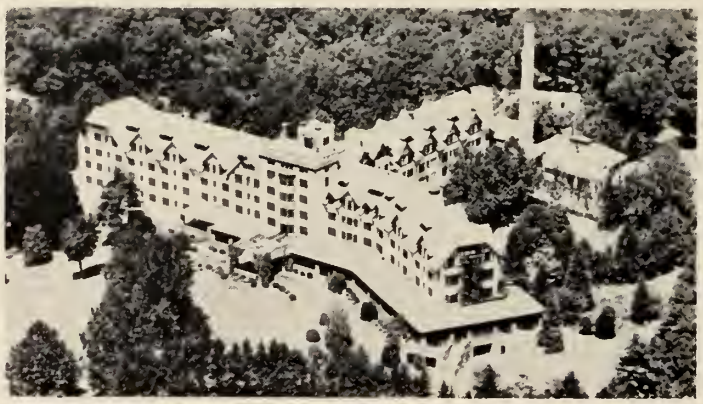
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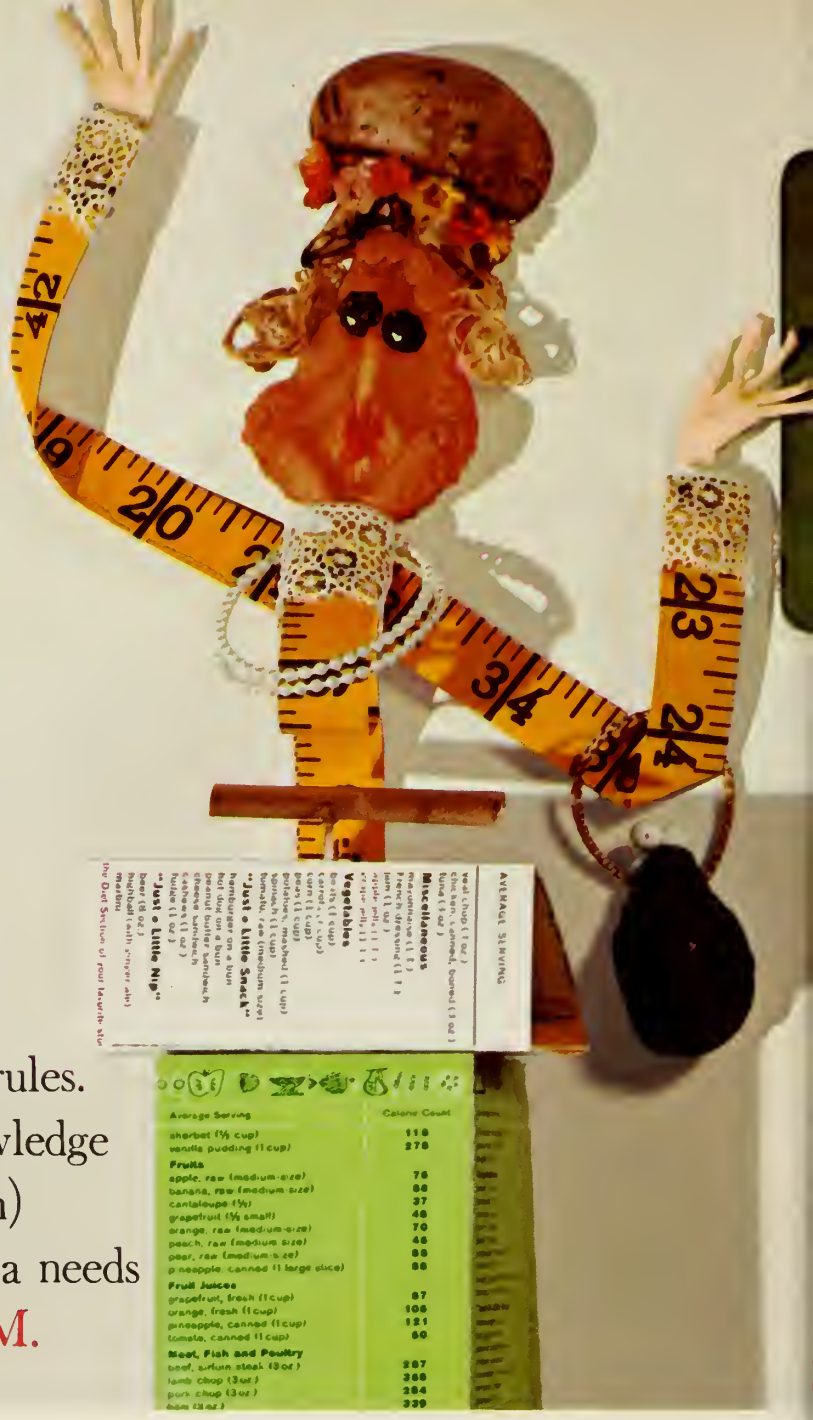
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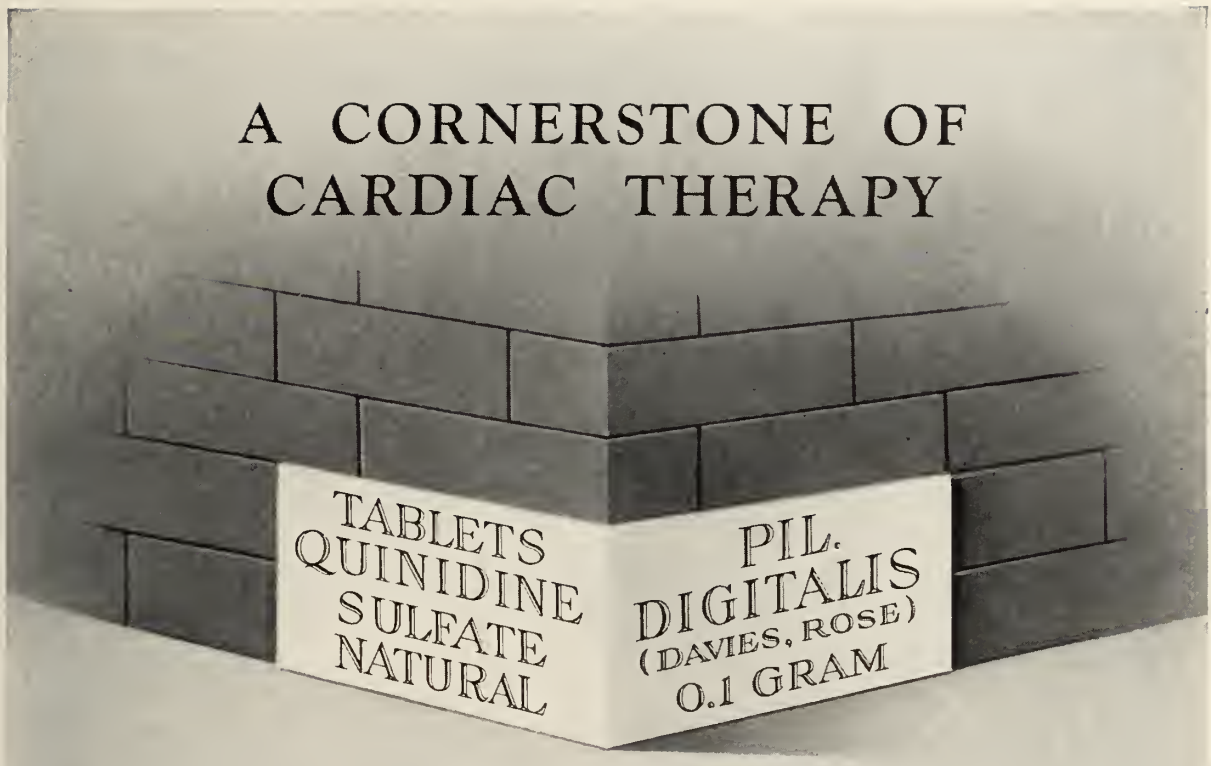

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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**arthritis** "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

**digestive diseases** Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

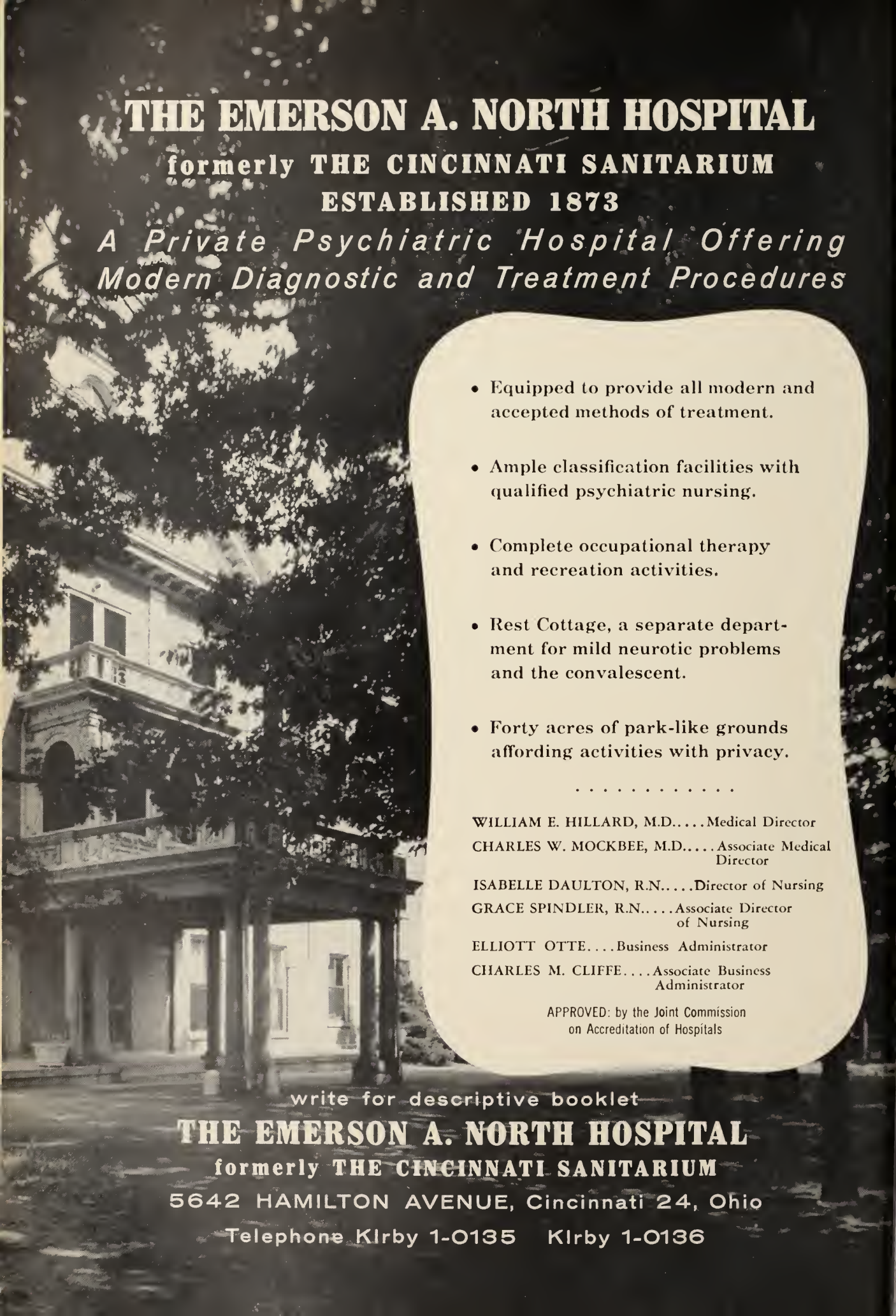
**degenerative diseases** "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

**infectious diseases** Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

**diabetes** Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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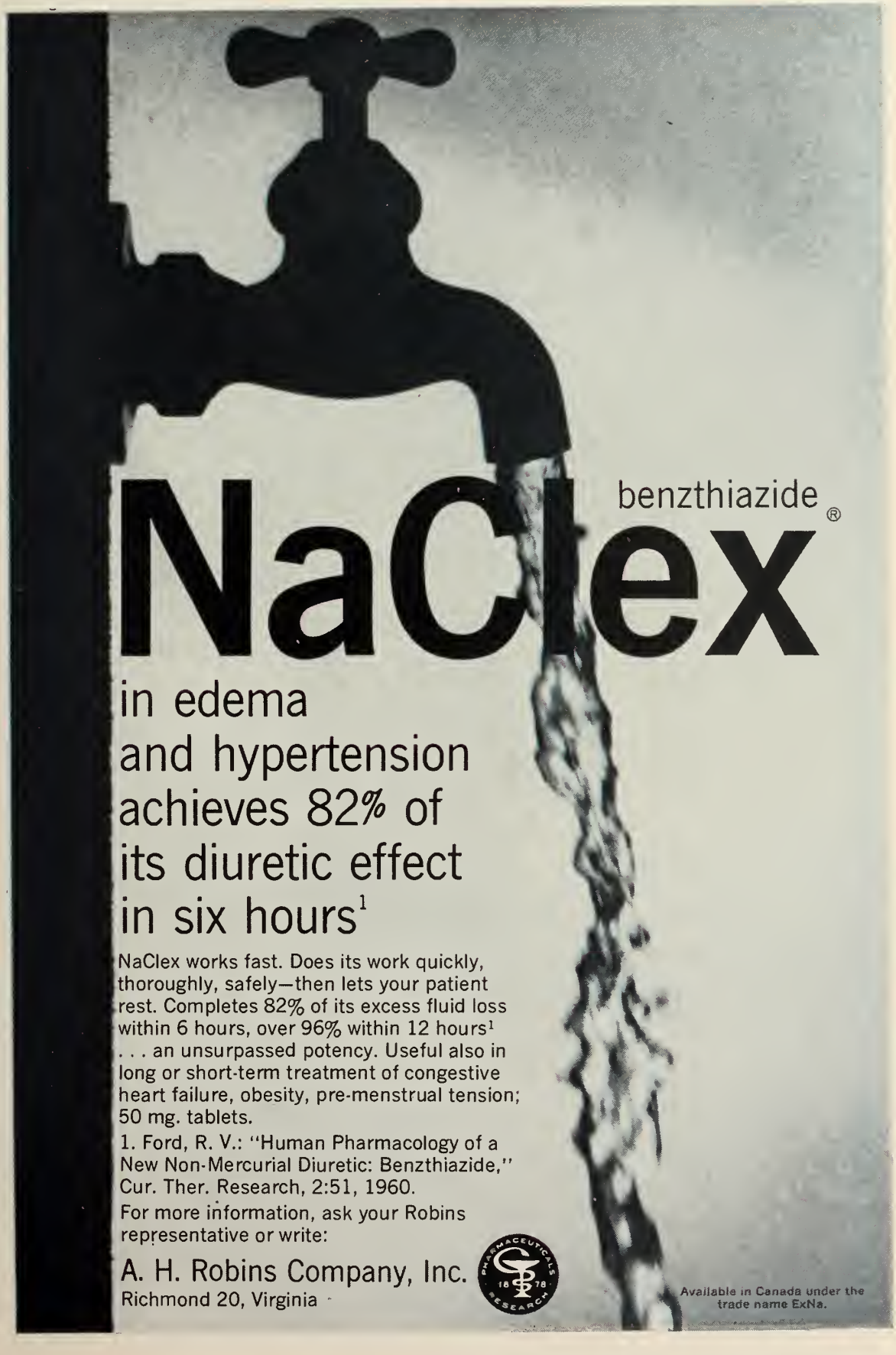
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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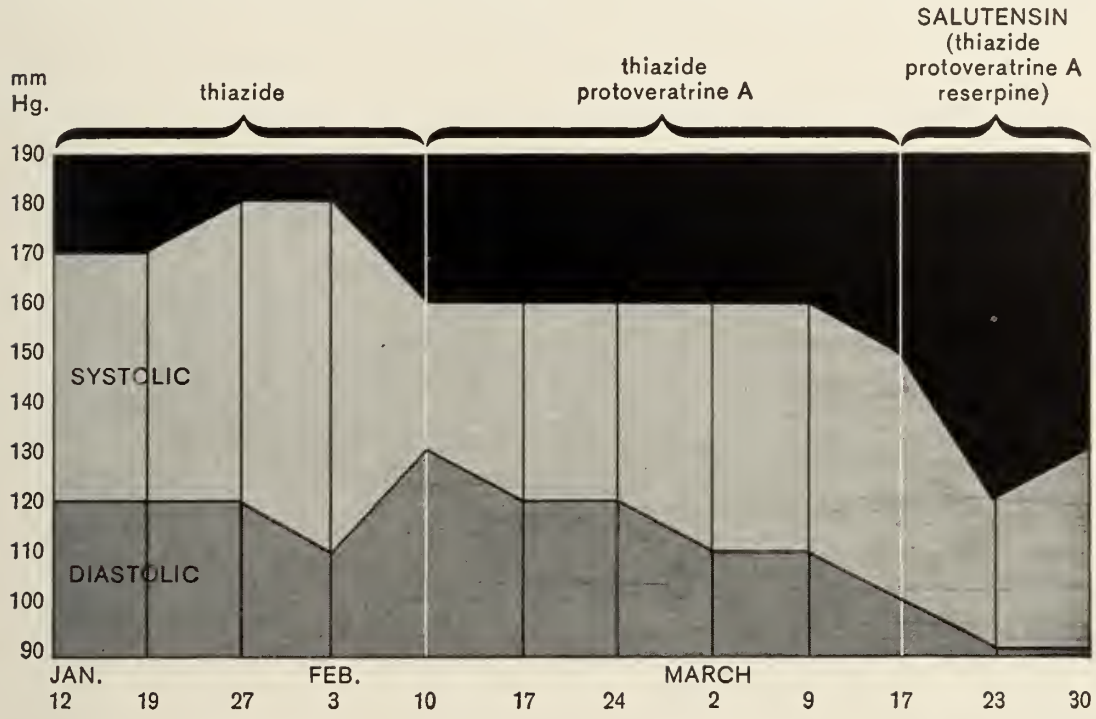
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**References:** 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

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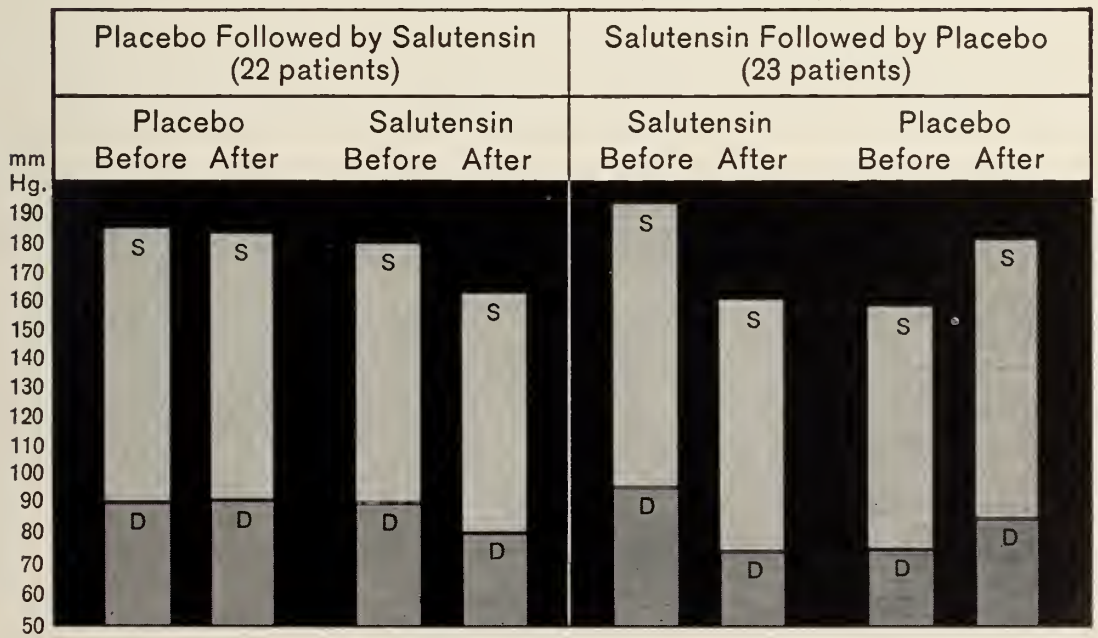
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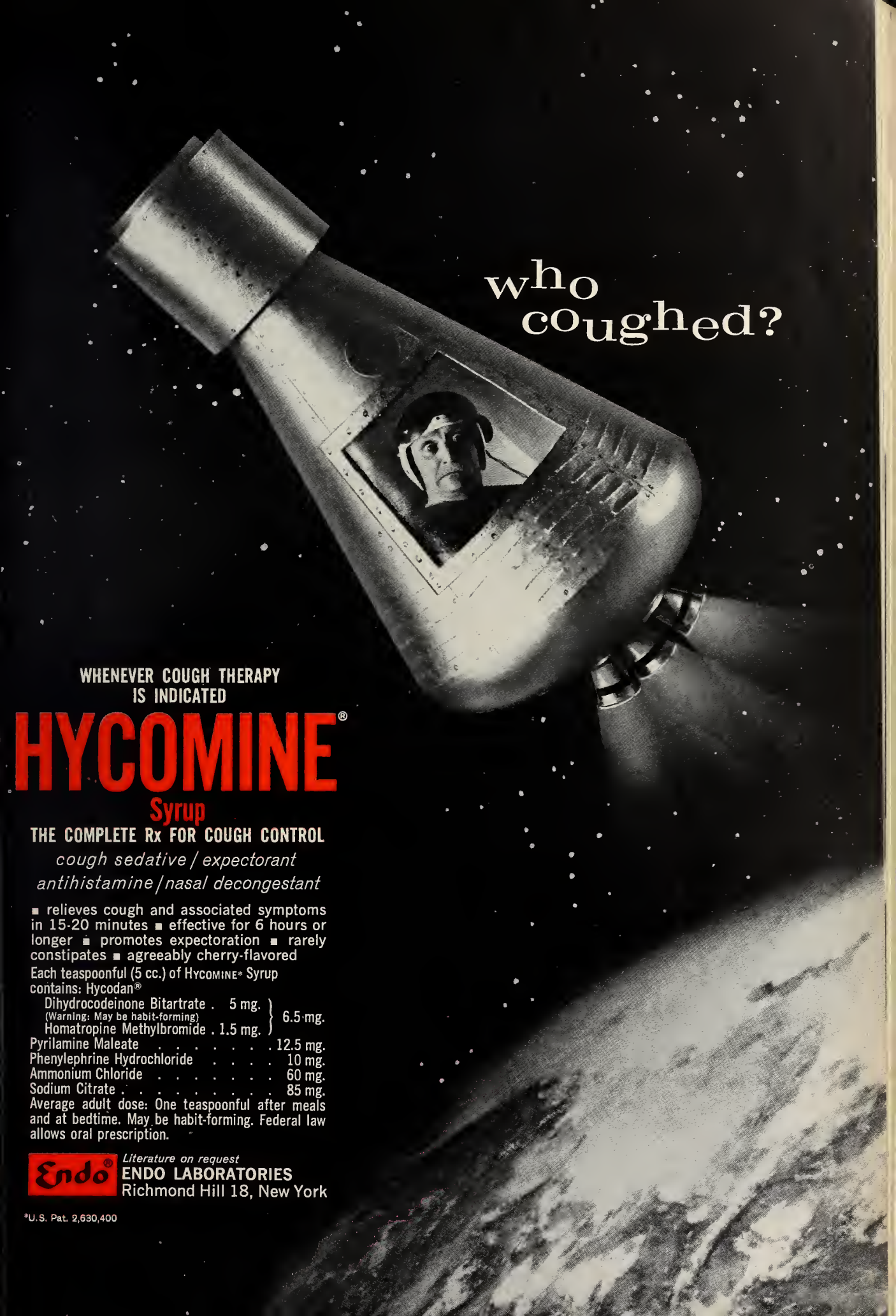
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References:

[1]Bastian, J. W.: Classification of CNS Drugs by a Mouse Screening Battery. To be published in Intern. Arche. de Pharmacodynamie; [2]Hubata, J. A., and Hecht, R. A.: Review of Clinical Use of Hydroxyphenamate (Listica) in 1,759 Patients. To be published in Clinical Medicine; [3]Taub, S. J.: Management of Anxiety in Allergic Disorders—New Approach. To be published in Psychosomatics; [4]Cahn, B.: Experience with a New Tranquilizing Agent (Hydroxyphenamate). *Ibid;* [5]Davis, O. F.: On Use of Hydroxyphenamate in Anxiety Associated with Somatic Disease. To be published; [6]Alexander, L.: Effect of Hydroxyphenamate on Conditional Psychogalvanic Reflex in Man. Supplement to Diseases of the Nervous System, Sept., 1961; [7]Cahn, B.: Effect of Hydroxyphenamate in Treatment of Mild and Moderate Anxiety States. *Ibid;* [8]Cahn, M. M., and Levy, E. J.: Use of Hydroxyphenamate (Listica) in Dermatological Therapy. *Ibid;* [9]Eisenberg, B. C.: Amelioration of Allergic Symptoms with a New Tranquilizer Drug (Listica). *Ibid;* [10]Friedman, A. P.; Pharmacological Approach to Treatment of Headache. *Ibid;* [11]Greenspan, E. B.: Use of Hydroxyphenamate in Some Forms of Cardiovascular Disease. *Ibid;* [12]Gouldman, C., Lunde, F., and Davis, J.: Clinical Trial of Hydroxyphenamate in Alcoholic Patients. *Ibid;* [13]McLaughlin, B. E., Harris, J., and Ryan, E.: Double Blind Study Involving "Listica," Chlordiazepoxide, and "Placebo" as Adjunct to Supportive Psychotherapy in Psychiatric Clinic. *Ibid;* [14]Bastian, J. W.: Pharmacology and Toxicology of Hydroxyphenamate. *Ibid;* [15]Bossinger, C. D.: Chemistry of Hydroxyphenamate. *Ibid.*


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# A Bridge for the Chasm Between Doctors and Lawyers

**Medical Facts for Legal Truth,** edited by Oliver Schroeder, Jr., LL. B. ($12.50, *The W. H. Anderson Company. Cincinnati 1, Ohio.)* Lawyers are often critical of physicians because of their reluctance to testify in court, and they accuse us, among other things, of a "conspiracy of silence." On the other hand, physicians complain because they feel that lawyers play fast and loose with medical facts and ethics. The courts we say, make a mockery of our system of education and the certification of "experts" by giving more credence to a physician's courtroom manner than to his professional training and ability and the facts he presents. And what, we ask, does a lawyer know of the bugaboo of clinical coincidence that plagues us constantly in the practice of medicine? Hold on, say the attorneys, physicians have only a rudimentary concept of the lawyer's role as advocate and of the importance of such distinctions as that between probability and possibility. These are some of the reasons for the chasm that certainly does exist between the two professions.

The purpose of this book (from the Law-Medicine Center at Western Reserve University) is to deal with that chasm. It is better defined in the introduction by the editor as follows: "To bring truthful medical facts into the legal process is the primary challenge; to use wisely these truthful medical facts in the administration of justice is the secondary challenge. The major tool for bridging the chasm between law and medicine is education. With education, understanding grows. With understanding, truth emerges. With truth, justice thrives." . . . "Doctor, lawyer, decision maker will find here the essential background material which is the starting point to obtain medical facts so necessary to provide legal truth in the administration of justice in a free society."

Although the organization of chapters impresses me as rather haphazard, I agree that the authors have gone a long way toward these goals. Three chapters should be especially interesting and valuable for the purpose of helping physicians to understand the Law. First is The Medical Memorandum — A Lawyer's Tool, by Mr. Schroeder. After a brief discussion of the purpose and technique of preparing this memorandum, he presents sample memoranda of the medical and legal arguments in two interesting cases. Next, in a very well written chapter entitled Medical Ethics and the Law, Mr. Clinton DeWitt clarifies many of the questions that trouble physicians who are faced with a court appearance. Last, Dr. Samuel Gerber, in Expert Medical Testimony and the Medical Expert, presents a considerable body of practical advice for the medical witness.

The other chapters deal with specific medical problems. While interesting, they will probably be of more value to lawyers than to doctors. It is not made clear just why these particular problems were included and others such as orthopedics, neurology, etc., were not.

**Doctors, Patients, and Health Insurance,** by Herman Miles Somers and Anne Ramsay Somers. ($7.50, *The Brookings Institution, 1775 Massachusetts Avenue, N. W., Washington 6, D. C.)* This is a study of how medical care is organized and financed in the United States. The changing character of medical practice, the modern hospital, and the drug industry is described and the medical consumer with his longer life expectancy, his new patterns of illness, new expectations and demands is studied. The spiralling costs, and their causes, are analyzed. The financing institutions are examined as well as the industrial health and welfare plans, Blue Cross, Blue Shield, commercial insurance, and the comprehensive prepayment plans.

Special attention is given to the problems of controlling costs, of insuring the aged, of extending insurance coverage to drugs, dentistry, psychiatric care, and to other widely discussed issues. Finally, the book explores the doctor-patient relationship. The authors weigh the evidence and indicate the direction in which medical care is likely to move in the United States.

**Quinones In Electron Transport,** by G. E. W. Wolstenholme and Cecilia M. O'Connor. ($11.00, Ciba Foundation Symposium, *Little, Brown & Company, Boston 6, Mass.)*

**Chemicals in Your Food and In Farm Produce: Their Harmful Effects,** by Franklin Bicknell, M. D. ($2.95, *Emerson Books, Inc., 251 West 19th Street, New York 11, N. Y.)*

**Light Coagulation,** by Gerd Meyer-Schwickerath, M. D., translated by Stephen M. Drance, F. R. C. S. (Eng.) ($9.50, *The C. V. Mosby Company, St. Louis 3, Mo.)*

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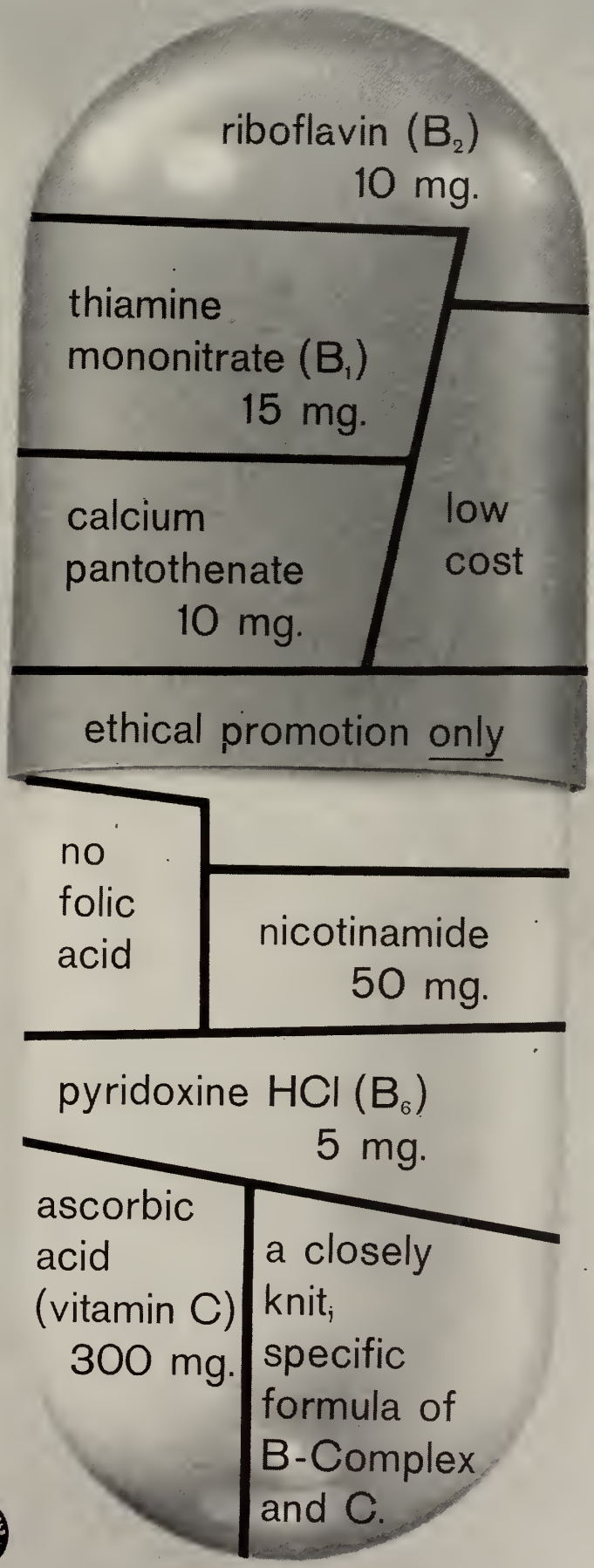
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The Historian's Notebook

# Richard Gundry's Observations On Insanity, 1860

PHILIP C. ROND, M.D.*

## Part II

*(Continued from December, 1961, Issue)*

IT WAS FELT in the mid 1800's that insanity was on the increase. However, the psychiatrist (alienist) of that period did not fail to recognize that perhaps this was more apparent than real, because "cases are now more readily known, recognized and collected."

### Social Psychiatry

Dr. Gundry attributed the seeming increase in the incidence of insanity to "the increased pressures of living." "The greater susceptibility to nervous impressions and liability to hyperaesthesia, is shown in the great increase, in the community, of liability to headaches, to dyspepsia, to hysteria, and especially in the diminished power of resistance shown to physical depressing agents." He gives as an example of the effects of modern living a comparison of the Indian woman who has her child and immediately returns to work, while the middle class mother of the 1860's, who although she has a relatively easy labor, is shocked by it, and requires a long and tedious convalescence. "If civilization adds to knowledge and happiness, if it also intensifies individual pleasure by elevating its sources, it also distills from the same alembic, to mix with these sweets, some subtle and prevading poisons for the torture of the individual."

Has the world really changed so much in the past 100 years? Yes. But the people are the same, they are only being re-discovered.

To continue from Dr. Gundry, "The same influences of civilization which thus assist the prevalence of hysteria, neuralgia, epilepsy, and others, depend upon the disturbance of the equilibrium of the nervous forces, which tend to diminish the powers of resistance to all disease and may undoubtedly play a part in the production of insanity."

Dr. Gundry (along with many of his associates) felt that the weather had an influence on the development of insanity.[4] He expressed that in less disturbed people 'feeling under the weather' was probably an acknowledgment of this obscure and little understood association. He reports on a case presented by a Sir Woodbine Parrish, on the effect of a certain north wind in Buenos Aires, especially on one Antonio Garcia, age 35 to 40 years: "An educated man of considerable civility and amenity of manner; countenance open and generous. When the wind blew he became irritable, quarrelsome and committed violence. He would develop dull headache, impatience, etc. If near a gambling house he couldn't resist the temptation to gamble."

Dr. Gundry felt that age played an important part in the development of insanity. He mentions statistics from United States asylums which indicated age 20 to 30 years was the most common period for cases to be admitted to asylums. He mentions "our distinguished colleague, the pioneer in psychological medicine in our State, Dr. Awl states, it appears that the largest number of persons become insane between the ages of 20 and 30 years." He goes on to observe that there is an excess in the general population of individuals between the ages of 20 and 30 and therefore, it may not follow necessarily that this decade is more favorable to the development of insanity.

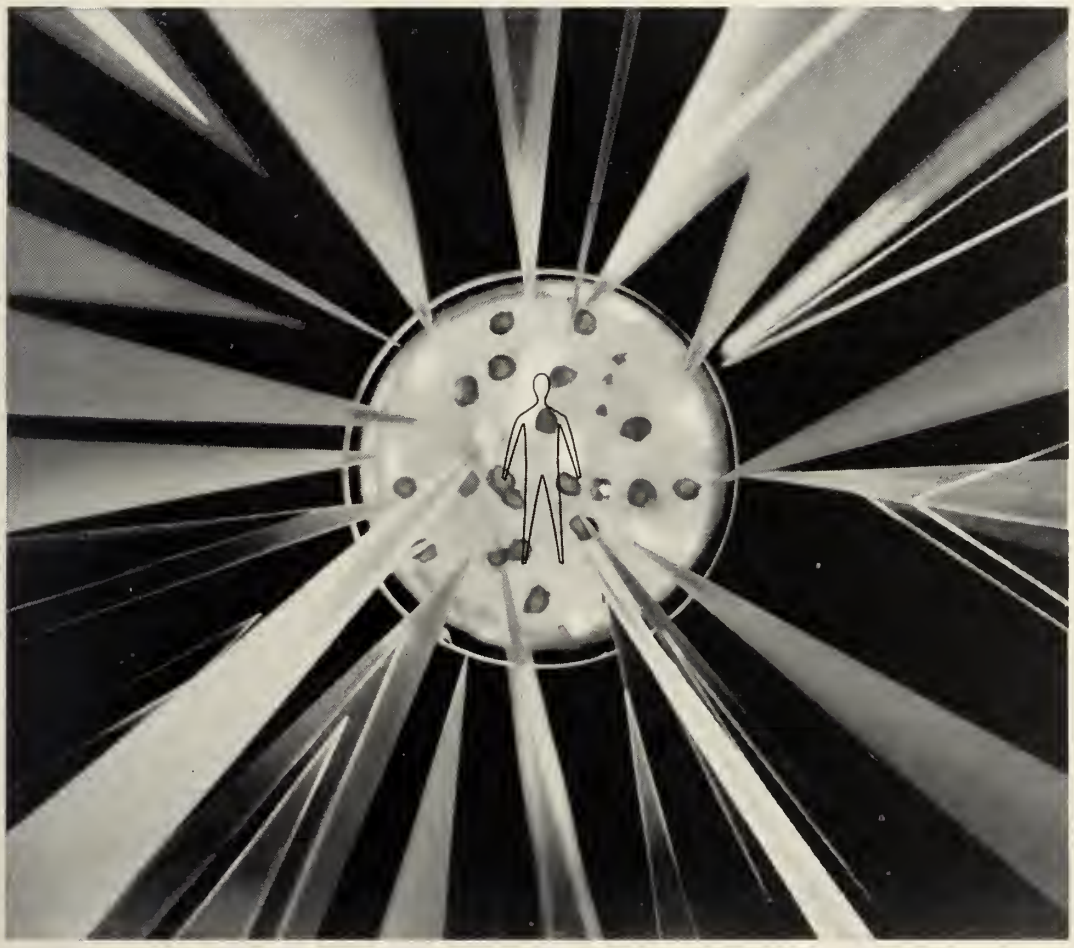
He was interested in the incidents of insanity in men as compared to women. He tried to understand the effect of celibacy upon the production of insanity. He observed that meager reports were available on this subject, and he concluded that perhaps the higher number of cases of insanity in single individuals was perhaps due to the effect of insanity rather than the cause of it. Occupation studies as related to insanity in this era were, he felt, of little value.

### Physical Versus Moral Causation

He was interested as were most other psychiatrists of his time in a comparison of physical versus the moral (emotional) causes of insanity. In the great majority of cases it was Dr. Gundry's impression that in insanity both classes of agencies were involved

Presented before the Ohio Academy of Medical History at the annual meeting held at Granville, Ohio, April 22, 1961.

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in the overthrow of reason. A table available in this period assigned, as the cause of insanity from the reports of 17 mental hospitals, 111 distinct physical and 79 moral causes. The conclusions drawn that physical causes outnumbered moral causes in the production of insanity was not supported by European psychiatry. This however, did not turn him from his impression that the physical causes greatly preponderated in the origin of mental disease.

Under physical causes he listed ill health of various kinds, zymotic diseases, as malaria, typhoid; diseases of the nervous organs, such as apoplexy, paralysis, etc.; diseases of the respiratory organs (pthisis, bronchitis); disturbances of the circulative organs, as excessive blood loss, heart disease, etc.; disturbances of the digestive organs; disturbance of the generative organs; old age; violence; head injuries; exposure to sun, heat, cold, fumes, etc.; intemperance; and masturbation. Under this latter category he lists 142 cases and states "that this evil is of great magnitude, no casual observer in any of our hospitals will doubt, after witnessing the woebegone countenances, the lack-luster living, and the libidinous, shameless experience of those inveterate cases which they will meet in the wards. It usually blights the prospects of the most amiable youth of our country."

As to moral causes he states these have popularly been regarded as the most prolific sources of mental disorder. It remains to be shown how purely psychical phenomena can induce insanity. Dr. Gundry proposed that this might operate in one of the two following manners, (A) by direct action on the brain; (B) by indirect action through the production of physical disturbance elsewhere in the body which then affect the brain. He felt the chosen defense of the brain against insanity was sleep, saying "it was useful to restore the tired and worried brain,— absolutely necessary for the restoration of the exhausted brain." Assigned causes of a moral nature were religious excitement, business perplexities, domestic troubles. At the conclusion of his observations on moral causes of insanity he re-emphasizes the importance of sleeplessness in the production of insanity and states "so rarely do we see a recent case of insanity that is not preceded by want of sleep, that we regard it as almost a sure precursor of mental derangement."

In conclusion, although Dr. Richard Gundry died in the State of Maryland, he really belongs to early Ohio Psychiatric History. He spent 23 of his 36 years in active psychiatric work in the State Hospital System of Ohio. He wisely reflected the opinions held by psychiatrists throughout the world in his time and added his own astute observations. He struggled to make original contributions, which have left their mark upon Ohio and American psychiatry. He was eulogized by the Medical and Chirurgical Faculty of the State of Maryland at the time of his death in the following manner, "keeping pace with the rapid progress of psychology, he was able with his subtle intellect to master all its details, and thus he became an authority among his co-workers."[5,6]

Through correspondence with Rachel K. Gundry, M. D., a granddaughter of Richard Gundry, we know that he left three physician sons, all of whom specialized in psychiatry (Richard Fitzharris, Louis Henry, and Alfred Thomas — the latter the father of Rachael K. Gundry[7]). They each had private sanitaria in Maryland. The Gundry Sanitarium, Athol, was founded by son Alfred T. Gundry in November 1900. It continues today under the operation of Rachael K. Gundry. It would seem that Dr. Richard Gundry not only contributed to the psychiatry of his time through his personal efforts but to the psychiatry of the future through his children and grandchildren.

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## How Ohio Counties Were Named

(See also *The Journal*, p. 1486, November 1960; p. 111, February; p. 768, July; p. 878, August; and p. 1240, November, 1961)

*Pickaway* (1810): A variant of the Shawnee Indian word "Piqua" meaning "man risen out of the ashes."

*Pike* (1815): In honor of explorer Zebulon M. Pike.

*Portage* (1807): Named for old Indian carrying path in area.

*Preble* (1808): Named for Captain Edward Preble, who distinguished himself as a naval commander in the Revolution and the War of 1812.

*Putnam* (1820): Named for Revolutionary War General Israel Putman.

*Richland* (1812): Name was taken which described the soil.

*Ross* (1798): Named for James Ross, Pennsylvania politician.

*Sandusky* (1820): From the Indian word meaning "cold water."

*Scioto* (1803): From Indian name Scioto, meaning "deer."

*Seneca* (1824): Named for Seneca Indians who lived in county.

*Shelby* (1819): In honor of Isaac Shelby, Kentucky governor.

*Stark* (1808): Named for Gen. John Stark of Bunker Hill fame.

*Summit* (1840): So named because it was the highest point on the Ohio canal.

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# Cancerocidal Drugs

## Use in Perfusion of Isolated Tumor Bearing Areas

ALFRED N. GEREIN, M.D., JOHN A. WOODHAMS, M.D.,
and FREDERICK S. CROSS, M.D.

PERFUSION of isolated tumor bearing areas with cancerocidal drugs is the result of a series of ingenious observations and developments. In 1946 Gilman[1] reported the biologic actions and therapeutic applications of nitrogen mustard. The radiomimetic effect of this agent on tissue was noted, and its use for treatment of malignant disease was suggested. Since then, several cancerocidal drugs have been introduced for the treatment of malignant diseases. The use of these drugs has been limited by their systemic toxicities, particularly on the gastrointestinal tract and the hemopoietic system.

Since the intravenous administration of cancerocidal drugs within limits of normal tissue tolerance is without cancerocidal effect and since larger amounts of these drugs may be dangerous to life, Klopp and associates[2] in 1950, administered fractional doses of nitrogen mustard to localized tumor areas by intra-arterial injections. It was noted that this method of drug administration produced a more pronounced effect on the tumor with diminished systemic toxicities as compared to the intravenous administration of nitrogen mustard. Grey[3] and Churchill-Davidson, et al.[4] in 1957, reported increased tumor cell sensitivity to irradiation when the oxygen tension around the tumor cell was high and noted oxygen administration at the time of irradiation would greatly increase the effectiveness of irradiation in bringing about tumor regression. Cole[5,6] has demonstrated experimentally that nitrogen mustard and thio-tepa will prevent or diminish the percentage of "takes" in rats inoculated with a suspension of Walker 256 cells when the drugs are given after inoculation of these cells. It was also demonstrated that these drugs are more effective when administered before or immediately after tumor cell inoculation than 12 to 24 hours later. Ryan and associates[7] in 1957, reported on selective perfusion of isolated viscera with cancerocidal drugs using an extracorporeal circuit. These advancements have made

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From the Department of Surgical Research, Division of Surgery, St. Luke's Hospital, Cleveland. Supported by The Elizabeth Severance Prentiss Foundation.
Submitted May 9, 1961.

it possible to perfuse isolated tumor bearing areas for a moderate period of time under high oxygen tension with large amounts of a cancerocidal drug complicated by little or no systemic toxicity.

The purpose of this paper is to present our clinical experience in perfusing isolated tumor bearing areas with cancerocidal drugs, using an extracorporeal circuit.

Following are the *indications* for this form of treatment:

1. Adjunct to the standard method of treatment.
2. Treatment of localized, nonresectable tumors.
3. Convert nonresectable to resectable tumors.
4. Palliation for advanced malignancies.
5. Primary treatment.

Whenever possible, perfusion of the tumor bearing areas with a cancerocidal drug is used as an adjunct to the standard accepted methods for treating a specific tumor. Only under unusual circumstances is perfusion used as a primary form of treatment.

Safe and effective perfusion of an isolated tumor bearing area requires special *equipment, medication* and *techniques*. These requirements are as follows:

1. Anatomical isolation of the tumor area.
2. Pump oxygenator.
3. Arterial and venous pressure manometers.
4. RISA and counting chambers.
5. Blood, heparin, and protamine.
6. Cancerocidal agents.
7. Knowledge of perfusion techniques.
8. Knowledge of postoperative care and complications.

### Anatomic Isolation

Perfusion of tumor bearing areas presupposes anatomical isolation. Since the circulation to the tumor bearing area cannot be totally isolated from the general circulation in all anatomical areas, two methods for perfusion have been developed. They are: (1) isolated perfusion for the areas that can be anatomically isolated and (2) balanced perfusion for the areas that cannot be anatomically isolated.

In an *isolated perfusion* the circulation to the area is completely isolated from the systemic circulation with a pneumatic cuff appropriately placed. Such a perfusion results in little or no mixing of the perfusing blood and the cancerocidal agent with the systemic circulation. Hence, there is little or no systemic toxicity.

In a *balanced perfusion* the collateral circulation is controlled by balancing the perfusion blood pressure against the systemic blood pressure. Balancing the respective blood pressures minimizes mixing of the systemic blood with the perfusing blood. However, regardless of how well the respective pressures are balanced, a significant amount of mixing occurs. This may result in severe systemic toxicities. These toxicities are minimized by determining the rate of mixing during the perfusion, using $I^{131}$ and adjusting the dosage of the cancerocidal drug accordingly. With this precaution systemic toxicities can be maintained within safe limits and yet a maximum amount of the cancerocidal drug can be delivered to the tumor bearing area.

### Extracorporeal Circuit

The extracorporeal circuit used for perfusing isolated areas consists of a rotating disc oxygenator and a venous and an arterial sigmamotor pump. The nine inch oxygenator is primed with 1000 cc. of heparinized fresh blood. The temperature of the blood in the oxygenator is maintained at 37°C with a siliconized wire coil wrapped around the cylinder and connected to a Variac. Throughout the perfusion, venous and arterial perfusion pressures are monitored with a water and mercury manometer respectively. The patient is given sodium heparin 0.75 mg. per pound of body weight before the artery and vein are cannulated. Two thirds of the heparinizing dose in mg. of protamine is administered to restore the normal clotting mechanism when the cannulas are removed.

The blood volume of the general circulation is determined using $I^{131}$ before perfusion is begun. During the perfusion, serial samples of blood are withdrawn from the systemic circulation at 5 to 10 minute intervals to determine the rate of mixing between the two circulations.

### Administration of Cancerocidal Drugs

There are several cancerocidal drugs available for perfusing isolated tumor bearing areas. These drugs and the recommended dosage for the respective areas have been reported,[8] and are shown in Table 1. Of these agents, nitrogen mustard remains the drug of choice because of its cancerocidal effect, and because its duration of action in blood is limited to about eight minutes. The dose of nitrogen mustard to be administered depends upon the area to be perfused and the weight of the patient. This dose may have to be modified depending upon the amount of mixing that may occur during the perfusion. The dose is administered in four aliquots at five minute intervals. These aliquots are injected into the arterial side of the arterial pump. By injecting the drug at this site satisfactory mixing with the blood is assured. It also assures that the drug will reach the tumor bearing area before it becomes inert. After the total dosage of the drug is administered the area is perfused for 15 minutes. At the end of the perfusion the blood

TABLE 1. *Carcinocidal Agents and Dosage mg./kg.*

| Drug | Arm | Leg | Pelvis | Head & Neck |
|---|---|---|---|---|
| 1. Nucleotnxic Drugs | | | | |
| a) Nitrogen mustard | 0.4 | 0.8 | 0.8 | 0.25 |
| b) Phenylalanine mustard | 1.0 | 1.5 | 1.5 | |
| c) Triethylenethin-phosphoramide | 0.6 | 0.8 | 1.0 | 0.7 |
| 2. Cytoplasmotoxic Drugs | | | | |
| Actinomycin D | 0.035 | 0.05 | 0.05 | |
| 3. Antimetabolite Drugs | | | | |
| 5-Fluorouracil | 15.0 | 20.0 | 20.0 | |

in the isolated area is drained, the pneumatic cuff is released, the cannulas are removed, and the artery and vein are repaired. The total perfusion time is 40 minutes when nitrogen mustard is used.

### Perfusion Techniques

The major artery and vein in the isolated area are cannulated with appropriately sized hard Bardex cannulas. Experience has proven that a better perfusion is obtained if the major artery and vein are cannulated at their origin. The pneumatic cuff is inflated to 350 mm. Hg. over the hard cannulas so that the cannulas are open to the extracorporeal circuit at one end and to the tumor bearing area at the other. If smaller, more peripheral vessels are used for perfusion there is difficulty in establishing a good venous return in spite of a high venous pressure. Since the major vessels in the tumor bearing area have been cannulated at their origin, venous return has not been a problem.

The arterial and venous pressure cannulas are inserted into a lesser artery and vein. The rate of venous and arterial pumping is adjusted so that satisfactory venous and arterial pressures are maintained.

The rate of perfusion at the start is low. At this time the venous return from the area is less than the arterial input. During this time an increment increase in the arterial input will exceed the venous return. Within 5 to 10 minutes the perfusion will balance so that the arterial flow will result in an immediate and corresponding increment rise or fall of the venous flow. A satisfactory arterial perfusion pressure may vary from 60 to 120 mm. Hg. In a balanced perfusion a satisfactory arterial perfusion pressure equals the systemic blood pressure. The venous pressure is maintained between 0 and 200 mm. of water.

The venous blood returning to the oxygenator is exposed to a gas mixture containing 96 per cent oxygen and 4 per cent carbon dioxide. The flow rate of this gas mixture is 5 liters per minute. With this gas mixture, oxygen saturation determinations of the blood leaving the arterial end of the oxygenator is 97-100 per cent. High oxygen saturation of tumor tissue is important since this increases the radiomimetic effect of the cancerocidal drug on the tumor.

### Results

To date nine perfusions have been performed on eight patients. These patients are summarized in Table 2.

TABLE 2. *Clinical Experience*

| Pt. | Age | Diagnosis | Area Perfused | Indication |
|---|---|---|---|---|
| 1 | 46 | Melanoma | Pelvis | Palliative |
| 2 | 11 | Rhabdomyosarcoma | Left leg | Adjunct |
| 2 | 12 | " | " | " |
| 3 | 59 | Melanoma | Head and Neck | " |
| 4 | 10 | Fibrosarcoma | Left Arm | " |
| 5 | 35 | " | " | " |
| 6 | 14 | Chondroblastoma | Left Leg | " |
| 7 | 42 | Undiff. Sarcoma | Pelvis | Primary Rx |
| 8 | 49 | Melanoma | Left Arm | Adjunct |

Two of the eight patients perfused have died of their disease. Patient 1 had a palliative perfusion for a wide regional disseminated melanoma. This patient died from her disease one year after perfusion. Perfusion was the primary form of treatment in patient 7, who had an undifferentiated sarcoma of the left acetabulum. This patient died of her disease seven months after perfusion. In six of the eight patients, perfusion was used as an adjunct to surgical resection of the tumor or amputation. Two of these six patients developed a local recurrence after perfusion. Patient 2 had the involved area perfused a second time followed by excision of the local recurrence. Patient 3 had a simple excision of the local recurrence. At present these two patients are free of local recurrence or distant metastasis. Four of the six patients perfused as an adjunct to resectional therapy developed no local recurrences and are clinically free of distant metastasis. In summary, two of the eight patients have died from progression of their disease. Six of the eight patients are alive and well with no sign of recurrence or distant metastasis one to three years after perfusion. There has been no perfusion mortality using the described technique and nitrogen mustard.

*Perfusion morbidity* was variable and depends upon the area perfused, the amount of drug administered, the venous pressure in the perfused area, the method of perfusion, the amount of mixing, and upon whether previous surgery was performed in the isolated area. In general, perfusion of the lower extremity resulted in better perfusion with fewer complications than perfusion of the upper extremity. The severest complications were encountered when the distal half of the upper or lower extremity was perfused. In these instances, the venous pressure in the isolated area was high while the venous return was poor. Postperfusion edema, neuritis, and temporary loss of function may develop in the extremity. Under these circumstances the complications were severe if a large amount of drug was administered. More severe complications may be anticipated if the patient had previous surgery in the area being perfused. These difficulties are exemplified in the following two cases.

**Patient 5,** a 35 year old woman, had a fibrosarcoma of the left arm excised on two previous occasions. Each excision was followed by a recurrence of the tumor. After the second recurrence, perfusion of the arm followed by amputation was recommended. The patient consented to perfusion but refused amputation. During the perfusion, a high venous pressure developed in the isolated area while the venous return from the area was poor. The predetermined dose of nitrogen mustard was administered in spite of a poor perfusion. After perfusion, the patient developed severe edema, neuritis and pain in the extremity. Two weeks later the patient consented to amputation of the extremity and thereby received the treatment initially

suggested. Three years after this treatment the patient has no sign of recurrent disease or distant metastasis.

Patient 8, a 49 year old woman had a subungual melanoma of the left thumb. The distal phalanx of the left thumb was amputated and the left epitrochlear and axillary lymph nodes were excised. Three weeks later, this patient had the left forearm perfused with nitrogen mustard. During the perfusion, the venous pressure was high and the venous return was poor. The predetermined dose of nitrogen mustard was reduced because the perfusion was not considered satisfactory. Postperfusion edema, neuritis and loss in the range of motion developed in the fingers of the left hand. The edema and neuritis subsided completely while the range of motion of the digits improved slowly.

These two cases illustrate certain important points referable to this form of cancer therapy. If the patient has had previous surgery in an extremity, the venous and lymphatic drainage from the extremity may be sufficiently impaired that perfusion is attended by high venous pressure and poor venous return. If an unsatisfactory perfusion persists, it is wise to reduce the amount of drug administered to the area or the danger of losing the limb is great. This does not create a problem if immediate amputation is to follow the perfusion. At present all lesions in an extremity, regardless of the site, are perfused through cannulas inserted at the origin of the major artery and vein supplying the involved area. This results in an excellent perfusion with a low venous pressure and a good venous return. This modification in the perfusion technique has significantly reduced the postperfusion morbidity.

The *postperfusion complications* and their recommended treatment are listed in Table 3. In a satis-

TABLE 3. *Complications and Treatment*

| Complications | Treatment |
|---|---|
| 1. Exceeding Local Tissue Tolerance | |
| a) Petechiae, Erythema | Ice bag |
| b) Edema | Elevation |
| c) Tanning and Blistering | Cortisone |
| d) Gangrene | Amputation |
| 2. Leakage Factor | |
| a) Hemoglobin 10 Gm. | Blood transfusion |
| b) Platelets 30,000 | Platelet rich plasms |
| c) Leukopenia | Antibiotics and cortisone |
| d) Fever | Antibiotics |
| 3. Wound Healing Retarded | |

factory isolated perfusion, complications are localized to the isolated area. They result from the high concentration of the cancerocidal drug administered to this area. No systemic complications were encountered when an isolated perfusion was performed. In a balanced perfusion, if complete mixing occurs, systemic toxicities involving the hemopoietic system predominate. This is exemplified in patient 7, a 42 year old woman, who had a balanced pelvic perfusion for an undifferentiated sarcoma of the left acetabulum. Complete mixing occurred after 25 minutes of perfusion. The leukopenia that developed is illustrated

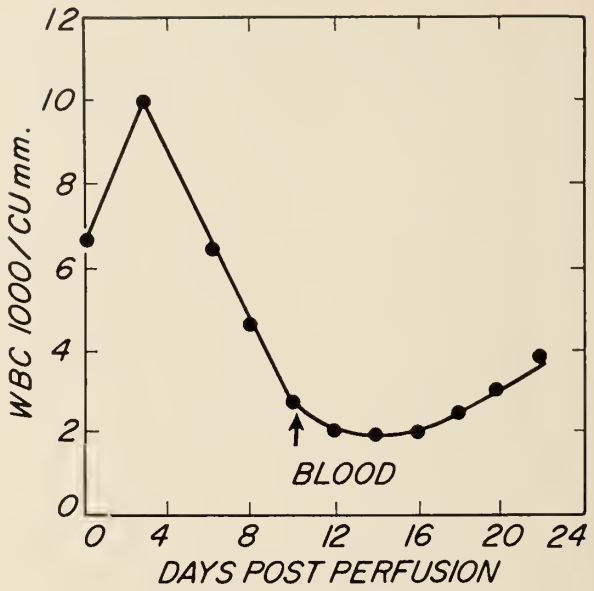



FIG. 1. *Illustrates the postperfusion leukopenia that developed in Patient 7. After an initial rise there was a gradual decrease in the WBC until the tenth postperfusion day. Thereafter the white blood cell count gradually returned to normal.*

in figure 1. After an initial rise in the white blood cell count a gradual leukopenia developed until the tenth postperfusion day. Thereafter the depressed blood elements gradually returned to normal. In all cases, a significant delay in wound healing was noted. Primary wound healing occurred in all cases except one which healed gradually by secondary intention.

## Discussion

Several routes for administration of cancerocidal drugs have been tried with varying results. The intravenous route has the disadvantage of producing systemic toxicities without significant cancerocidal effect. The intra-arterial administration of these drugs yields better therapeutic results with diminished systemic toxicities. But, in any event, the amount of drug delivered to the tumor bearing area is small while systemic toxicities may be severe. In certain selected cases, it is possible to obtain maximum cancerocidal effect with minimal to no systemic toxicities, when the tumor bearing area is isolated and perfused with a cancerocidal drug using an extracorporeal circuit. This technique delivers and confines the administered drug to the isolated area. Under these circumstances the tumor bearing area received 10 to 20 times the amount of drug it would otherwise receive if the drug were administered by a systemic route. Confining the drug to the isolated area minimizes systemic toxicities and thereby does not impair host resistance. Since host resistance is unimpaired, x-ray therapy need not be excluded from the therapeutic armamentarium in the treatment of a specific tumor. In fact, x-ray therapy may be used as an adjunct to perfusion.

Perfusion of isolated tumor bearing areas is indicated whenever anatomical isolation of the tumor bearing area is possible. Under these circumstances, it can

be used to treat localized but nonresectable neoplasms. In other instances, it may be used to convert nonresectable lesions to resectable ones. Perfusion may also be used as a primary form of treatment in patients who refuse excisional therapy. In still other instances, perfusion may be used as an adjunct to x-ray therapy. It is felt that perfusion can be used to best advantage if it precedes excisional therapy. This adjunct to excisional therapy may decrease the viability of disseminated tumor cells resulting from surgical manipulation and thereby decrease the potential number of distant metastases. It is conceivable that such a combined attack on a malignant neoplasm may give the patient the maximum chance for cure.

Adequate perfusion of isolated tumor bearing areas requires special equipment and medications and a thorough knowledge of perfusion techniques. When these requirements are met, this form of cancer therapy can be performed with a low mortality and a morbidity that is acceptable for the nature of the disease being treated. As perfusion techniques are better understood fewer and less severe postperfusion complications can be anticipated. Although experience in this technique has been limited, certain factors have come to light which result not only in a better perfusion, but in perfusions with fewer and less severe complications. This may be accomplished by cannulating the major artery and vein supplying the tumor bearing area at their origin. This permits a high flow perfusion with good venous return and a low perfusion venous pressure. Patients who have had previous surgery in the isolated area may have some impairment to venous and lymphatic drainage. Under these circumstances, it may be wise to reduce the amount of the cancerocidal drug to be administered, otherwise severe postperfusion complications may be encountered. Alternatively, in an isolated perfusion where the venous return is poor and the venous perfusion pressure is high, the isolated perfusion may be converted to a balanced perfusion. This conversion will lower the venous pressure in the isolated area and result in some mixing with the systemic circulation, but the resultant morbidity will be less. Postperfusion complications are minimal when the described technique is used and modified to suit the individual patient.

The amount of mixing that occurs during a perfusion depends upon the method of perfusion and the area perfused. In an isolated perfusion of an extremity less than one per cent mixing occurs in 40 minutes. This small amount of mixing results in no systemic toxicities. A balanced perfusion of a similar extremity results in about 25 per cent mixing in 40 minutes. This amount of mixing produces no significant systemic toxicities, yet a large amount of the drug is administered to the tumor bearing area. A balanced pelvic perfusion results in complete mixing in 25 minutes. Complete mixing gives severe systemic toxicities unless the amount of drug administered is adjusted and kept within safe limits.

Our clinical experience with this form of treatment is limited to nine perfusions in eight patients with a one to three year follow-up. Two of the eight patients died of their disease. Six of the eight patients have no local recurrence or distant metastases. In the two patients that died, perfusion of the tumor bearing area was performed for palliation. In six of the eight patients perfusion preceded excisional therapy and was used as an adjunct to excisional therapy. This combined attack on a malignant tumor does not permit a comparative evaluation of perfusion with other methods of cancer therapy, nevertheless it is felt that this two-fold attack on a malignant tumor will give the patient a maximum chance for cure. Needless to say, better results may be anticipated as perfusion techniques improve and as better cancerocidal drugs are made available.

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EMOTIONS IN HEART DISEASE. — My inclination is toward the role of inborn errors of metabolism as preponderant over the influences of environment. Were we to capture that will-o-the-wisp, a satisfactory test to define *individual* liability to coronary disease, I venture to say that the nonsusceptibles could eat what they wished, work as they wished, and indulge in any of the more appealing vices without cardiovascular retribution. — Howard B. Sprague, M. D., Boston, Mass.: Emotional Factors in Coronary Heart Disease. *Circulation:* XXIII/5:648-654, May 1961.

# Relationship Between Human and Bovine Tuberculosis in Ohio

## An Epidemiologic Study

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ALTHOUGH Koch himself at one time believed the bovine tubercle bacillus was nonpathogenic for man,[1] other workers soon disproved this theory.[2,3] Relatively recent reports from the British Isles[4,5,6] describe the isolation of bovine bacillus from 4.1 per cent to 23.4 per cent of human patients having nonpulmonary tuberculosis. These serve to illustrate the continuing importance of bovine to human transmission in this disease.

Conversely, laboratory and field studies have demonstrated that infection of cattle with human strains can and does occur.[3,7] It has been suggested that herdsmen infected with the human strain could present a definite problem in the eventual eradication of tuberculosis in cattle in the United States.[8]

The study reported here was designed to gain preliminary information on possible interrelationships between bovine and human tuberculosis in Ohio.

### Materials and Methods

The Division of Animal Industry, Ohio Department of Agriculture, routinely forwards to the Division of Communicable Diseases, Ohio Department of Health, autopsy reports on all cattle reacting to the intradermal tuberculin test. In the spring of 1960, a roster was compiled of all herds in Knox, Licking, Logan, Morrow and Union Counties in which reactor cattle had been discovered since January 1, 1960.

Another list was prepared consisting of the accredited tuberculosis free herds in these same five counties, which had been re-accredited since January 1, 1960. No reactors had been found in any of these herds for a minimum of 25 years.

One of the authors (R. M.) visited all farms on these lists and solicited the cooperation of the farmers for this study. They were interrogated regarding human and animal health histories and management practices, and this information was recorded on a standard form.

Whenever possible, the Mantoux test was administered to the occupants of the farms as follows: 0.1 ml. of intermediate strength P. P. D. was inoculated intradermally on the medial aspect of the forearm. The results were read at 48 hours. Reactions of 5 mm. erythema and induration were considered positive. All Mantoux positive individuals were referred to their family physicians for chest x-ray and physical examination.

In Licking County, the tests were administered and interpreted by the staff of the Licking County Tuberculosis Sanatorium. In Union County, the visits were made and tests conducted by the nursing staff of the Union County Health Department.

When possible, tuberculin reactor cattle were followed to slaughter and specimens were collected from the cervical, thoracic, and mesenteric lymph nodes as well as all visible lesions. All specimens were examined by culture, animal inoculation, and microscopy.

The specimens for isolation were emulsified and then digested for 72 hours with 18 per cent tri-sodium phosphate. This solution was changed at 24 and 48 hours. The specimens were then centrifuged for 20 minutes at 2000 rpm and the supernatant fluid discarded. Two rinses were performed with distilled water. Then, each specimen was planted on six tubes of Hohn's medium. One tube was kept in complete darkness at 37°C. The others were maintained for eight weeks without specific light exclusion, two at 37C° and one each at 25°, 45°, and 42°C.

The digested specimens from a given cow were pooled. Four ml. quantities of the pooled specimens

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from each cow were then inoculated into each of two guinea pigs, one intraperitoneally and the other by the subcutaneous route. The animals were observed for eight weeks and then autopsied.

The sections for microscopy were stained by the Ziehl-Neelsen method.

## Results

A total of 99 farms was visited in this study, representing 66 reactor and 33 accredited herds. Of these, cooperation was obtained on 51 and 31 farms respectively. Although the only obvious selection was the tuberculin status of the cattle, these herds were markedly different (P less than 0.005) in herd size and breed distribution (Table 1). The herds did not differ in management practices such as the use of natural or artificial breeding, other species of animals maintained, or pasturing of different species together.

TABLE 1. *Size and Breed Distribution of Selected Tuberculin Reactor and Accredited Cattle Herds in Ohio*

| Breed | Reactor Herds | | Accredited Herds | |
|---|---|---|---|---|
| | Number Herds | Mean Size | Number Herds | Mean Size |
| Ayrshire | 1 | 90.0 | 1 | 80.0 |
| Guernsey | .... | .... | 9 | 63.1 |
| Holstein | 30 | 41.5 | 9 | 61.4 |
| Jersey | 2 | 37.0 | 6 | 46.3 |
| Shorthorn | 2 | 47.0 | 1 | 12.0 |
| Mixed | 29 | 27.1 | 2 | 81.5 |
| Unspecified | 2 | 59.0 | 3 | .... |
| Total | 66 | 36.5 | 31 | 59.1* |

*Calculated from the 28 herds of known size.

One management practice somewhat different (P=.03) in the two groups was the time cattle were last purchased for addition to the herd. Additions within each time interval up to 10 years were reported twice as often on the reactor farms as on the accredited.

Of 97 farms where the information could be obtained, unpasteurized milk produced on the farm was consumed by the occupants of 73 (75.3 per cent). Knowledge that the herd had contained tuberculin reactors did not markedly alter this practice, for it still existed on 45 (68.2 per cent) of the 66 reactor farms.

Two hundred and fifty individuals were tuberculin tested on the farms where raw milk was consumed and the reaction in 20 (7.9 per cent) was positive. Only three of 72 persons (4.2 per cent) were tuberculin positive on those farms where pasteurized milk was used. This difference is not statistically significant (P greater than 0.1). Every family contacted in this study reported using meat produced on their own farm. Only six families did their own butchering.

Of the 51 reactor farms cooperating on this study, cattle from 14 of them had visible lesions of tuberculosis at autopsy. Fifty-four persons were tuberculin tested on these 14 farms, but only one was found positive (1.9 per cent). In contrast, 7.1 per cent (12 of 170) of the persons were tuberculin positive on the farms where the tuberculin reactor cattle had no gross lesions at autopsy. This is not a significant difference (P greater than 0.1). There was also no apparent correlation between the human tuberculin sensitivity rates and the degree of contact with the cattle.

As expected, there was a marked increase in the rate of tuberculin positivity in the older age groups of people in this study (Table 2.) The apparently lower rate of tuberculin sensitivity on reactor farms appeared to be a combination of this difference in age specific rates and the large number of individuals under 20 years of age on the reactor farms.

There was no apparent difference in the sex specific tuberculosis rates of the persons tested for 13 of 177 men were positive (7.3 per cent) and 10 of 148 women (6.8 per cent). A markedly higher rate was found in those persons presenting a history of contact with tuberculous individuals. Since only 13 people presented such a history the number was too small for statistical evaluation.

As described under Material and Methods, specimens were collected from three cattle with lesions and five without detectable lesions. These cattle represented three herds, two from Allen County and one from Trumbull County. All specimens were negative on animal inoculation, culture, and histopathological examination.

No active human tuberculosis was disclosed as a result of this study.

## Discussion

A fine degree of cooperation was encountered in this study—(82.8 per cent of the families, 76.1 per cent of the individuals on the cooperating farms). This suggests that this approach might be used effectively for other diseases.

The only significant livestock management differences disclosed in this study were breed of cattle,

TABLE 2. *Age Specific Tuberculin Sensitivity Rates in a Selected Rural Ohio Population, 1960*

| Age | TUBERCULIN STATUS OF HERD | | | | | | TOTAL | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | REACTOR | | | ACCREDITED | | | | | | |
| | Human Contacts | Humans Tested | No. Pos. | Human Contacts | Humans Tested | No. Pos. | Human Contacts | Humans Tested | No. Pos. | % Pos. |
| 1 - 20 | 139 | 106 | 2 | 43 | 33 | 1 | 182 | 139 | 3 | 2.2 |
| 21 - 40 | 78 | 62 | 3 | 27 | 25 | .... | 105 | 87 | 3 | 3.4 |
| 41 - 60 | 67 | 43 | 4 | 32 | 30 | 4 | 99 | 73 | 8 | 11.0 |
| 61 + | 17 | 9 | 4 | 14 | 13 | 5 | 31 | 22 | 9 | 40.9 |
| Unspecified | 4 | 4 | .... | 6 | .... | .... | 10 | 4 | .... | 0.0 |
| Total | 305 | 224 | 13 | 122 | 101 | 10 | 427 | 325 | 23 | 7.1 |
| Per Cent Positive | | 5.8% | | | 9.9% | | | 7.1% | | |

herd size, and time since last purchase. Considering that cattle infection is determined by reaction to the intradermal tuberculin test and not frank clinical disease, it is doubtful that this reflects a true breed difference in resistance to disease. It is suggested, however, that further comparison of records of reactor and accredited herds might reveal common factors delineating high risk herds. It cannot be questioned that frequent additions to the herd through purchase is a poor practice unless performed under more stringent conditions than are usually observed. It is not inconceivable that herdsmen with large herds of a single breed (purebred?) could be expected to be more interested in proper management than herdsmen with smaller herds and mixed breeds.

In contrast to other reports[3,4,5,6,7] the tuberculin status of the herds reported here seemed to have no apparent effect on the status of the farm inhabitants, suggesting that the two factors operate independently. This was further supported by the relative unimportance of raw milk consumption and extent of the disease in the herd as measured by autopsy findings.

While interspecies transmission of tuberculosis between cattle and man does not appear to be a major problem in Ohio, we should not overlook the possibility of interaction occurring in isolated instances.


## Summary

Ninety-nine dairy farms of known tuberculin status were visited and 224 persons tuberculin tested. An attempt was made to correlate the findings and elicit a pattern regarding possible interrelationships between the disease in animals and man.

On the farms studied, it seems unlikely that the bovine and human tuberculosis problems are closely related epidemiologically. This should not rule out further studies in this area.

Examining the characteristics of reactor and accredited herds might suggest a means of determining high risk herds for control purposes.


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EPINEPHRINE IN GLAUCOMA.— In this study 70 eyes were uncontrolled in that either the intraocular pressure was high (>21) or the coefficient of outflow was low (>.18) while the eye was receiving the maximum tolerated medical therapy.

"In each case when epinephrine therapy was begun it was administered as the 2 per cent solution [Glaucon], 1 or 2 drops in the conjunctival cul-de-sac once or twice daily. The previous medical program was unchanged. When improvement in 'C' was noted (i. e., when 'C' became (>.18), the amount of medical therapy was gradually reduced. In many patients, after several months, the coefficient of outflow and intraocular pressure became normal."

"IOP was controlled, that is, always less than 22 mm. Hg., in 58 of the eyes (83 per cent), and uncontrolled despite prolonged maximum therapy in 12 eyes (17 per cent). Of these 58 eyes, in which IOP was controlled following the instillation of epinephrine, 'C' improved in 49 eyes (70 per cent). 'C' was recorded as having been improved when it became greater than 0.12 and 50 per cent greater than it had been prior to the institution of epinephrine therapy."

The improvement of "C" was subsequently lost in 10 eyes. Glaucon therapy of seven eyes had to be discontinued because of local allergy. In addition two eyes of one had to be discontinued from therapy because of intolerable burning and redness of the eyes.

This is the first instance of an anti-glaucomatous agent which promotes an improvement in "C" on prolonged therapy. With miotic therapy, improvements in "C" are gradually lost, even with increased dosage. Two per cent epinephrine permits reduction of miotic and carbonic anhydrase inhibitors, while maintaining the high coefficient of outflow.—*Abstract:* Ballintine, E. J., and Garner, L. L.: Improvement of the Coefficient of Outflow in Glaucomatous Eyes During Prolonged Local Treatment with Epinephrine. *Archives of Ophthalmology,* Vol. 66, No. 3, September 1961.

# The Conservative Management Of Rheumatoid Arthritis

## A Review of Experience with Drugs Other Than Gold and Corticosteroids*

CHARLES W. DENKO, Ph. D., M. D., and FRANCIS W. McCOY, M. D.

THE management of the patient with chronic rheumatoid arthritis may tax the ingenuity of the most skilled therapist as this protean disorder fluctuates in its clinical manifestations. The problems are especially troublesome if the patient does not respond satisfactorily to a basic conservative program or if he develops an intolerance to a drug. Further indication of the fact that no single drug program as yet suffices for all patients with rheumatoid arthritis is the continuing production of new, purportedly antirheumatic drugs whose introduction follows a scanty preliminary clinical trial. The difficult task of drug evaluation falls on each physician even while he faces a daily barrage of gaudy advertising and enthusiastic detail men. This paper presents our experience with two of the newer agents, a muscle relaxant and the antimalarials.

### Salicylates

The place of salicylates in the basic conservative program is well established. Increased rest, adequate diet, salicylates for analgesia and proper physical therapy measures should constitute the basic treatment of rheumatoid arthritis. In a long-term study Short and his co-workers reported that 35 per cent of 174 patients observed over a 27 year period manifested persistent improvement.[1] Since salicylate therapy may be used for years it is important to find an inexpensive, safe agent. However, the plethora of salicylate-containing preparations with conflicting claims of superiority magnifies the problem of choosing a suitable preparation.

No adequate carefully controlled studies have yet been published that demonstrate any significant superiority of one agent over the others. The most widely used salicylate, plain aspirin or acetylsalicylic acid, is as effective as buffered aspirin in elevating serum salicylate levels and more effective initially than an enteric coated tablet containing sodium salicylate with para-aminobenzoic acid and ascorbic acid.[2] Probably the serum salicylate levels are influenced most strongly by the serum salicylate binding capacity rather than by the type of salicylate.

In patients who cannot tolerate salicylates, phenacetin or acetophenetiden may be used even though this is a less potent analgesic. The use of p-acetylaminophenol, a metabolic product of phenacetin, may be helpful. This agent known also as acetaminophen has been incorporated in many preparations including a liquid for children. The use of salicylate drugs containing phenacetin with caffeine and phenobarbital occasionally may be helpful in patients who do not respond to salicylates alone. However, the use of combination medications decreases flexibility in prescribing desired levels of salicylate. Scandinavian workers have reported that long term use of phenacetin in large doses such as may be taken by arthritis patients may result in kidney damage.[3] Table 1 lists some of the currently available salicylates in common use.

Agents such as dextro-propxyphene (Darvon®) and ethoheptazine (Zactirin®) are more potent analgesics but are not antirheumatic agents therefore they are not preferably used when antirheumatic drugs are available. Narcotics, such as codeine should not be used since arthritis is a chronic condition that may require

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From The Ohio State University Department of Medicine, Rheumatology Division, Columbus, Ohio. Submitted March 22, 1961.

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TABLE 1. *Salicylates Commonly Used in Management of Rheumatoid Arthritis*

| Generic Name or Composition | Trade Name |
|---|---|
| 1. Acetylsalicylic acid | Aspirin |
| 2. Buffered Aspirin | |
| a. aspirin, aluminum glycinate, $MgCO_3$ | Bufferin |
| b. aspirin, magnesium aluminum hydroxide | Ascriptin |
| c. soluble calcium acetylsalicylate carbamide | Calurin |
| 3. Enteric coated acetylsalicylic acid | Enseals |
| 4. Enteric coated combined salicylates containing: | |
| acetylsalicylic acid with | Ecotrin |
| p-aminobenzoic acid and | Pabalate |
| ascorbic acid | Pabasone |
| 5. Liquid Choline salicylate | Arthropan |
| 6. APC type | |
| acetylsalicylic acid with | APC |
| phenacetin and | Anacin |
| caffeine | Empirin |
| 7. Salicylate with phenobarbital | Phenaphen |
| phenacetin with acetylsalicylic acid and hyoscyamine and phenobarbital | |

treatment for many years and the undesired effects of addiction should be avoided.

## Phenylbutazone and Oxyphenbutazone

When more potent analgesic agents are desired in patients not obtaining enough relief with salicylates, two anti-inflammatory agents, phenylbutazone (Butazolidin®) and its hydroxy derivative, oxyphenbutazone (Tandearil®) are now available. Phenylbutazone has definite antirheumatic properties and is not simply an analgesic since patients may develop headaches while on this drug and receive no analgesic effect while the drug is used. Unfortunately its toxic effects occur more frequently in rheumatoid arthritis patients than in patients with other rheumatic disorders.[4] The principles involved in the use of phenylbutazone have been well covered in numerous reports and will be reviewed only briefly here.

Our experience with oxyphenbutazone indicates that it is a potent anti-inflammatory agent that is occasionally effective in patients who have failed to respond to phenylbutazone. Our usage of this derivative has followed the same pattern as that of the parent compound. The usual maintenance dose is 100 to 200 mg. daily taken at meals. Since it has been used only a short time an extensive evaluation of its potential toxic effects is not available. In preliminary observations only two patients reported gastric irritations severe enough to warrant discontinuance. However, we observe the same precautions and contraindications for its use as we do with phenylbutazone. As in phenylbutazone usage, leukocyte counts and hemoglobin determinations are done at the end of one and two weeks, then at increasing intervals to four weeks.

Since they do not produce the same systemic effects as steroids, phenylbutazone and oxyphenbutazone may be discontinued at any time without fear of a rebound of the arthritis that may occur when steroids are discontinued. When phenylbutazone and oxyphenbutazone are effective they produce a significant response in a few days. If the patient does not respond in one week the drug should be discontinued. Since toxic reactions increase with increasing dosages it is important to use the medication at the lowest compatible with adequate control of symptoms, usually one or two tablets (100 or 200 mg.) per day taken at meals. Occasionally a larger dose, 300 mg. per day, may be used for a short term. The physician must acquaint himself with their toxic properties in order to understand the place of phenylbutazone and oxyphenbutazone in his armamentarium against rheumatoid arthritis. An outline of principles in their use is presented in Table 2.

TABLE 2. *Use of Phenylbutazone and Oxyphenbutazone in Rheumatoid Arthritis*

| | |
|---|---|
| I. | **Indications** |
| | A. Acute inflammation of initial disease |
| | B. Acute flare during chronic course |
| II. | **Dosage** |
| | 100 to 200 mg. daily, occasionally 300 mg. (with meals) |
| III. | **Precautions** — Toxic reactions not uncommon |
| | A. Check leukocyte count and hemoglobin |
| | B. Observe patient for toxic reactions, rash, edema, gastric distress and blood element changes |
| IV. | **Contraindications** |
| | Avoid in patients with peptic ulcer, blood dyscrasia, drug hypersensitivity and congestive failure |

## Muscle Relaxants

The place of the muscle relaxants in managing rheumatoid arthritis needs to be re-evaluated. Earlier experience with agents of the meprobamate group was disappointing and led us gradually to discontinue their use. However, newer agents have been more reliable and effective. The best of these in our experience is chlormezanone (Trancopal®). Its effective mechanism is reportedly primarily through interference with neuronal transmission in the internuncial pool. It produces much less central nervous depression than do the reputed muscle relaxants which act primarily by depressing the central nervous system.

Since muscle spasm may serve as a protective mechanism to an injured joint muscle relaxation is not always desirable or necessary. However, there are occasions when patients with rheumatoid arthritis will benefit appreciably by the administration of chlormezanone, 300 to 800 mg. per day in divided doses. The main indications for its use have been spasms of large muscle groups, especially those around the hips, knees or shoulders. In patients who have steroid toxicity the drug is helpful in weaning the patient from steroids since muscle pain and muscle spasm may be prominent features of hypercortisonism. Occasionally patients who cannot tolerate salicylates



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will benefit from chlormezanone. If there is no appreciable benefit in three days on 300 or 400 mg. the dosage should be doubled. Once adequate control of muscle spasm is attained, the medication can be decreased to maintenance levels.

There have been no contraindications to the use of chlormezanone as yet. Chlormezanone may be given with any other antirheumatic agent without interference. The toxic reactions are uncommon. Occasionally gastric irritation may arise when the drug is taken on an empty stomach. Central nervous system effects manifest by drowsiness have occurred on dosages as low as 300 mg. per day. This problem is solved by lowering the dose to the effective level that will relieve spasm without causing sleepiness. Diarrhea was found in one woman in whom the drug was so effective it relaxed the anal sphincter and caused loss of control of bowel movements. When the drug was discontinued the diarrhea ceased, only to start again when the chlormezanone was re-instituted.

TABLE 3. *Principles in the Use of the Muscle Relaxant, Chlormezanone, in Rheumatoid Arthritis*

| | |
|---|---|
| I. | **Indications** |
| | A. Localized spasm of large muscles such as those around hips, knees and shoulders |
| | B. Steroid toxicity — in hypercortisonism for relief of muscle pain due to spasm |
| II. | **Dosage** 100 or 200 mg. 3 or 4 times a day |
| III. | **Precautions** — Toxic reactions rare<br>Occasional gastric irritation, central nervous depression, drowsiness, diarrhea (relaxation of anal sphincter) |
| IV. | **Contraindications** — None<br>Compatible with all anti-rheumatic drugs |

Principles in the use of chlormezanone are outlined in Table 3.

## Antimalarials

In 1940 Prokopchuk reported that acriquine or Atabrine® was effective in the treatment of lupus erythematosus.[5] This report was acclaimed as a significant study by several Russian investigators and was expanded with confirmatory effects being noted. In the post-war period, English workers reported that this drug aided patients with arthritis and skin lesions[6] and rheumatoid arthritis.[7,8] However, wider use of Atabrine and primaquine was hampered by undesirable toxic effects, even though they had anti-inflammatory effects in patients with rheumatoid arthritis.[9,10] Subsequent studies have noted the anti-rheumatic effect of chloroquine.[11,12,13,14] Although serious toxic reactions were few, the minor reactions were numerous and restricted its use.

Hydroxychloroquine (Plaquenil®), one of the recent antimalarial drugs, has been reported effective in the treatment of rheumatoid arthritis.[15,16] This agent has produced a lesser incidence of minor toxic reactions such as gastric irritation including nausea, flatulence, diarrhea and occasionally vomiting, and neurological symptoms such as blurring of vision and paresthesias. These symptoms disappeared upon reduction of dosage or discontinuance of the medication. No serious toxic reactions have yet been reported. In about 10 per cent of our patients these side effects have been of sufficient importance to warrant discontinuance of the drug.

A preliminary study lasting 15 months and covering 37 patients with rheumatoid arthritis is presented in Table 4. These patients were classified according

TABLE 4. *The Effect of Hydroxychloroquine in Rheumatoid Arthritis (Preliminary study of 37 patients for 16 months)*

| | Class | Response 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| Stage I | I | 4 | | | 1 |
| | II | 3 | | | |
| Stage II | II | 10 | | | 2 |
| | III | 3 | | | |
| Stage III | II | 3 | | | 1 |
| | III | | | 1 | |
| | IV | | | | |
| Stage IV | III | 1 | 4 | 1 | |
| | IV | 1 | 1 | 1 | |
| Total | | 25 | 6 | 6 | |

to the criteria of the American Rheumatism Association. They were stabilized patients who had been tried on other forms of therapy without satisfactory results. In various cases they continued to take salicylates, aurothioglucose, corticosteroid and phenylbutazone. Significant decreases in dosage of steroids were made possible during antimalarial treatment. Twenty-five patients (68 per cent) were thought to have significant improvement during the course of the study, while the remaining 12 had little or no benefit. These results need to be extended and confirmed by further tests including a double blind study.

Since this drug works slowly it should be given an adequate trial. The initial dose of hydroxychloroquine was usually 200 mg. three times daily, one tablet with each meal, a dose that could be tolerated by a majority of the patients. When it could not be tolerated, gastrointestinal distress was the usual reason, thereby requiring a reduction to a tolerated dose, 200 mg. once or twice daily. After two to four weeks the patient was re-evaluated. If no appreciable improvement could be determined the dosage was increased to 800 mg. per day or a higher maximum dose. Few persons could take as much as 1200 mg. daily without complaint. Patients were instructed to take the drug at meals, with food, or with antacids in order to minimize the gastrointestinal distress. If clinical improvement was apparent on any dose level that dosage was continued as long as improvement increased. When a plateau was attained then that patient remained on this dosage for about six months, then began a gradual reduction to maintenance levels which varied from 200 to 600 mg. per day. If no significant response to treatment

had occurred after two months of adequate hydroxychloroquine intake, the drug was considered to be ineffective and was abruptly discontinued. Perhaps a trial of three months' duration should be considered as an adequate trial.

Mechanisms of action of the hydroxychloroquine have indicated that it may exert its influence as an antirheumatic and anti-inflammatory agent through its action as an enzyme inhibitor, e. g. inhibition of adenosinetriphosphatase (ATP-ase) activity.[14] Antirheumatics such as chloroquine have been reported to have a common antibody-inactivating effect.[17] Perhaps they may function as chelating agents to remove metallic ions such as $Mg^{++}$ from enzyme reactions that are metallic ion or $Mg^{++}$ dependent such as ATP-ase. Perhaps hydroxychloroquine itself is not the immediate agent but one or more of its metabolic products may be responsible. Relatively large quantities, 600 mg. must be given for several weeks usually before a definite response occurs. Chloroquine may be effective since it may be converted in the body to hydroxychloroquine or some metabolic product similar to those derived from hydroxychloroquine. Further studies are indicated to obtain a better understanding of the mechanism of action of hydroxychloroquine. Principles in the use of hydroxychloroquine are outlined in Table 5. Similar procedures are applicable to the use of chloroquine although in smaller doses.

TABLE 5. *Principles for the Use of Hydroxychloroquine in Rheumatoid Arthritis*

| | |
|---|---|
| I. | Indications |
| | A. Chronic treatment, usually not effective in acute rheumatoid arthritis |
| | B. Steroid toxicity — to control disease as steroids are discontinued |
| II. | Dosage |
| | Usual initial dose is 600 mg. daily, 200 mg. with each meal |
| | Maximum dose 1200 mg. per day in divided doses |
| | Maintenance dose 200 to 600 mg. daily |
| | Therapy trial minimum of two or three months |
| III. | Precautions — Toxic reactions not serious |
| | Gastric disturbance (10% of patients) nausea, vomiting, flatulence, etc., dizziness |
| IV. | Contraindications |
| | Psoriasis |

## Summary

The management of the patient with rheumatoid arthritis is presented with attention centered on nonsteroid drugs. Principles involved in the effective use of the older antirheumatic drugs, salicylates and phenylbutazone, are set forth. The application of a new therapeutically active muscle relaxant, chlormezanone, is discussed. The place of antimalarials, especially hydroxychloroquine, in the long term management of chronic rheumatoid arthritis is outlined.

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IN THESE DAYS WHEN TRANQUILIZERS take the place of baby-sitters, blood transfusions are given thoughtlessly, indiscriminately and often needlessly, exposure to diagnostic or therapeutic ionizing radiation has become so universal, antibiotics are regarded as the cure-all for the most minor infections, and steroid therapy is the refuge of the destitute, it is small wonder that the old maladies are replaced by new man-made ones, and that allergies to a multitude of antigens have become so commonplace that they are said to exceed pathogenic microorganisms in number. What is powerful for good can be potent for evil. If we continually interfere with nature, we must pay the penalty. — William Boyd, M. D.: *A Textbook of Pathology*, ed. 7, Philadelphia, Lea & Febiger, 1961, p.5.

# Peripheral Neuropathy Due To Nitrofurantoin

## Case Report and Review of Literature

C. T. UESU, M. D.

NITROFURANTOIN (Furadantin®), one of the chemotherapeutic agents called nitrofurans, has become increasingly popular in the treatment of urinary tract infections because it has a wide antimicrobial spectrum, its use does not encourage the growth of resistant strains and, despite wide usage, reported toxicity has revealed only relatively minor and temporary side effects.

Among the side effects, gastrointestinal symptoms have been reported in as high as 33 per cent of patients receiving nitrofurantoin, and usually consists of nausea, less frequently of vomiting, and rarely of diarrhea, anorexia, or singultus.[1-4] Skin manifestations, although infrequent, include urticaria and on rare occasion, maculopapular rash, exfoliative dermatitis, pruritis, and alopecia.[4-9] Blood changes reported include mild eosinophilia and occasional leukopenia and hemolytic anemia.[1,4,10] Other types of complications include pulmonary infiltration and febrile reactions.[5,8,9]

Neurological symptoms such as headache, dizziness, nystagmus, nervousness, drowsiness in children, and peripheral neuritis[1,3,7] have also been reported on occasion; but in general the neurotoxic effects have not attracted much attention in this country. However, in the available European literature 14 cases of severe peripheral neuropathy have been reported.[11,13]

We have observed a patient who developed peripheral neuropathy, apparently induced by oral nitrofurantoin, which resulted in permanent motor and sensory deficits. Symptoms and signs of peripheral neuropathy developed insidiously at first, then progressed rapidly during the course of relatively high dosage and long-term administration of nitrofurantoin given to our patient who had a chronic urinary tract infection with marked renal insufficiency. Upon discontinuance of nitrofurantoin the acute symptoms ceased and progression halted. However, muscular atrophy and dysfunction persisted in spite of vigorous treatment for a period of one year. The time relationship between drug administration, pathological changes, discontinuation of the drug and cessation of the active disease process suggests that this was attributable to the effect of the drug.

Submitted April 20, 1961.

*The Author*

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### Report of Case

The patient, a 69 year old colored male janitor, was admitted to Brown General Hospital, Veterans Administration Center, Dayton, Ohio, on November 29, 1957. He had complaints of weakness, swelling of legs, shortness of breath and productive cough. His private physician prescribed digitalis and diuretics for congestive failure. The patient had undergone subtotal gastrectomy for benign prepyloric ulcer in 1950, and had been doing well two or three years prior to admission when he noted some weight loss and weakness. Except for a history of nocturia no other genitourinary symptoms were noted. The patient admitted to a heavy alcohol intake in the past, but not during the few months prior to admission. There was no history of exposure to poison or heavy metals, and no family history of diabetes.

**Physical Examination.** The patient's weight was 100 pounds, temperature 98.8°F, pulse rate 92 per minute, blood pressure 124/90. The patient was emaciated and appeared chronically ill, but was oriented and cooperative. Conjunctivae were pale. Tongue was normal. There was grade II hypertensive retinopathy. Dullness was noted in the left posterior base and crepitant rales noted at both bases. Cardiomegaly and grade III aortic and mitral systolic murmurs were also noted. The peripheral arteries were sclerotic. Moderate hepatomegaly was present. The prostate was enlarged. Three plus pitting edema was noted over both lower legs. Neurologic examination was entirely normal except for a slight tremulousness of the hands.

**Laboratory Data.** Blood studies on admission showed a white blood cell count of 5,000; neutrophils 64 per cent; lymphocytes 34 per cent; monocytes 1 per cent; eosinophils 1 per cent; hemoglobin 7.6 grams and hematocrit 28 VPC. Urinalysis on admission revealed a specific gravity of 1.005 with a pH of 5.5. Albumin and sugar were absent. Microscopic revealed only a rare epithelial cell. Blood urea nitrogen was 36 mg. per 100 ml. Serologic test for syphilis was negative.

**X-rays.** Chest x-ray on December 3, 1957, showed pleural thickening or fluid in the left chest, and bilateral peribronchitis with possible infiltration in the bases. Gastrointestinal series on December 4, 1957, revealed evidence of subtotal gastrectomy with a well-functioning anastomosis.

**Hospital Course.** On admission, the patient was in con-

gestive failure, due to probable arteriosclerotic heart disease, which responded to the usual cardiac management. Shortly after admission he developed signs of pneumococcal pneumonia which responded promptly to penicillin. Urinary tract studies revealed pyuria and repeated cultures of *E. Coli* and other flora. The persisting anemia was investigated by the hematology section and the feeling was that it was most probably due to chronic renal infection. No evidence of a postgastrectomy pernicious anemia was found.

Treatment of the urinary tract infection was started with Gantrisin,® one gram four times daily, on February 1, 1958, but pyuria persisted. Subsequent sensitivity studies revealed *E. Coli* organisms which were resistant to all available antibiotics and chemotherapeutic agents except nitrofurantoin (disc sensitivity testing methods were used). On February 15, 1958, Gantrisin was discontinued and he was treated with 100 milligrams nitrofurantoin four times daily. At this time the patient's blood urea nitrogen was 48 mg. per 100 ml. and hemoglobin average 7.7 to 8.6 grams per 100 ml. On this regimen, plus general supportive measures including blood transfusions, the patient's general condition improved, pyuria disappeared, and one urine culture at this time was negative. He received no other medications except oral vitamin B complex which was discontinued on March 13, when he was given a 30-day leave from the hospital.

He returned to the hospital on April 17. While at home the only medication the patient had received was nitrofurantoin, and he stated that his appetite had been good. He denied ingesting any alcohol but complained of some weakness. He was continued on nitrofurantoin and restarted on vitamin B complex. He continued to complain of weakness during the following month but this was considered to be a nonspecific complaint due to his anemia and general physical status.

On May 11, the patient started to complain of prickly sensations of the hands and feet. On May 15, he appeared weak, was somewhat lethargic and fasciculation of the arms was noted. The blood urea nitrogen had risen to 57 mg./100 ml., hemoglobin was 10.1 grams and it was felt that a decrease of renal function was responsible for his deterioration. By the following day he was extremely weak and was noted to have difficulty in closing his hands and holding objects. In the next 10 days the patient's hands became more affected and by May 26, he had completely lost his ability to grasp objects due to a combination of weakness and pain. Nitrofurantoin was discontinued. From this time on, the most prominent feature was pain and weakness of his hands and feet.

He was seen in neurological consultation by Dr. E. B. Lefken, on May 30, 1958, and a diagnosis of peripheral neuropathy, probably secondary to nitrofurantoin administration was made. Physical examination at this time showed diffuse muscle wasting of all extremities, most pronounced in the interossei muscles of the hand. All functions of the hands were impaired. There was hypoesthesia of all modalities, from elbow to hand and midthigh to feet. The patient was not able to stand or walk. Cranial nerves were intact. Deep tendon reflexes were hypoactive throughout. Speech and mental status were very good. Electromyographic examination confirmed the diagnosis of peripheral neuropathy. Lumbar puncture revealed clear fluid, normal pressure, and normal protein content.

Physiotherapy was started. Vitamin B-12, 1000 micrograms daily was given intramuscularly. The complaints of pain in the extremities diminished. Although he occasionally complained of coldness and appeared fretful, his hand strength definitely improved.

The patient's following year of hospitalization was relatively uneventful except for some periods of acidosis of renal origin. On cessation of nitrofurantoin therapy the patient's pyuria returned. An intravenous pyelogram done on July 15, 1959, showed bilateral contracted small kidneys of the nephrosclerotic type. A biopsy taken from the muscle in the left leg on June 8, 1959, was reported as showing sarcolemmic proliferation and atrophy of striated muscles. The interstitial tissue did not show inflammatory changes. Some of the nerve fibers showed degenerative changes. The small vessels were not remarkable. Amyloid stains were negative. The improvement of peripheral neuropathy was very slow in spite of vigorous physiotherapy. The patient was discharged from the hospital on October 31, 1959, without further improvement.

## Discussion

No case of severe peripheral neuropathy as a complication of oral nitrofurantoin administration has been reported in the American literature. Hasen, et al.,[1] in 1954, reported two instances of numbness of an extremity, possibly due to peripheral neuropathy, occurring among 107 nitrofurantoin treated patients but gave no details. Wildermuth[14] in 1955, described severe peripheral neuropathy, which occurred during the use of nitrofurazone (Furacin®), a congener of nitrofurantoin, which was given orally to a patient with metastatic testicular cancer. Mast[15] in 1960 reported a case of severe peripheral neuropathy associated with furaltadone (Altafur®), another congener of nitrofurantoin.

In 1956, Larsen and Bertelsen[11] reported a case of peripheral neuropathy occurring during nitrofurantoin treatment for urinary tract infection secondary to a tumor of the bladder in a 66 year old man. The patient's blood urea nitrogen had ranged from 47 to 51 mg. per 100 ml. The neuropathy occurred after 24 days of medication, a total dosage of 9.6 grams and responded to vitamin B and Lactoflavin. Olivarius[12] reported a similar case in a 64 year old woman with recurrent pyelitis and postulated toxic concentrations of the drug due to pre-existing severely compromised renal function. Onset of neuropathy was on the 23rd day with total dosage being 7.7 grams given in two series at eight days' interval. Blood urea nitrogen was 85 to 100 mg./100 ml. at the time neuropathy was found.

Briand and Tygstrup[13] in 1959, in a review of the European literature, listed seven additional cases of severe neuropathy, and four cases of mild paresthesia. They then described an additional case of a 40 year old woman who had nephrectomy for a kidney stone with recurrence in the remaining kidney accompanied by pyelonephritis, which was then treated with nitrofurantoin. The average daily dosage of 400 milligrams had been given almost continuously for six or seven months, when she developed signs of severe peripheral neuropathy and shortly thereafter died in uremia. Autopsy revealed noninflammatory neural changes including fragmentation, degeneration, and demyelinization of nerve fibers.

Available data on these cases and in our case revealed a fairly similar pattern of diffuse peripheral neuropathy. The onset was insidious and progression was variable. Symptoms developed first in either the upper or lower extremities, were always symmetrical and progressed centrally. The most common symptoms were paresthesia, numbness, and weakness. Hyperalgesia with severe pain in the distal extremities in our case, and general muscular pain in one other patient was noted. Common findings were dimin-

ished to absent deep tendon reflexes, hypesthesia or dysesthesia, and in some cases a complete loss of sensory perception. Muscular atrophy of the distal extremities with paralysis, especially of the extensor muscles with foot drop and wrist drop, was common. Less common signs were absent position sense, decreased vibratory sense, muscular twitching, and fretfulness. Cranial nerve involvement was not noted and spinal fluid examinations, which were done in only two cases, were normal.



Figure 1-A



Figure 1-B

FIG. 1-A AND FIG. 1-B. *Remaining muscular atrophy, one year after onset of peripheral neuropathy, despite rigorous treatment.*

These patterns of polyneuropathy are similar to those occurring in other peripheral neuropathies of diverse etiologies. The common denominator of the mechanism of the various etiologies of peripheral neuropathy is postulated to be disturbance of enzymatic reaction in carbohydrate metabolism.[16-20] Nitrofurans probably act as an enzyme-inhibitor in bacterial cells and in testicular and brain tissues.[21-23] Paul, et al,[23] found that such inhibition occurs in anaerobic formation of acetyl coenyzme A from pyruvate in an early step in Kreb's cycle. Therefore, nitrofurantoin and its con-

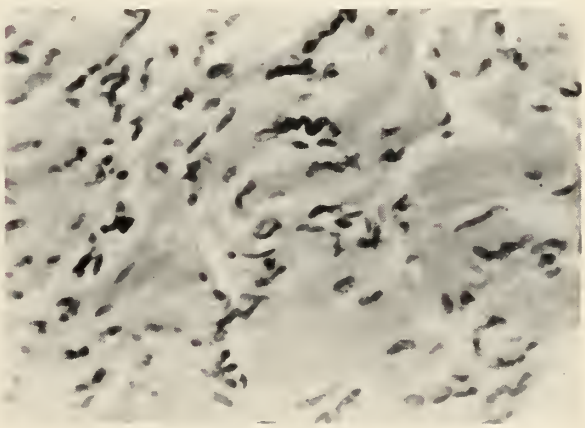


FIG. 2. *Biopsy of calf muscle at the same time as accompanying pictures taken.*

geners, because of their pharmacological properties, may be theoretically capable of producing peripheral neuropathy in a similar manner.

Although long-term, high dosage administration was a common factor in the four cases of nitrofurantoin-induced neuropathy, in which details are available, many other patients have received higher dosages over a longer period of time without developing neurological complications.[5,7,8] This would indicate that other factors are important. Of the four cases mentioned above, all patients had depressed kidney function. Impaired kidney function could cause the blood level of the drug to rise to a toxic level as postulated by Olivarius.[12] However, in addition to poor renal function, our patient had a past history of gastrectomy and heavy alcohol intake which, while not thought to be direct causes of the peripheral neuropathy, could well have been underlying contributing factors. Latent vitamin deficiency could have paved the way for a greater susceptibility to the toxic effects of the drug.

Larsen and Bertelsen[11] reported in their case a marked improvement of the peripheral neuropathy with administration of vitamin B-12 and Lactoflavin. However, in our case, multivitamins and massive

doses of vitamin B-12 did not seem to affect the course.

## Summary

A case of severe generalized peripheral neuropathy occurring during prolonged nitrofurantoin therapy is reported. Review of the literature would indicate that this was a rare complication but additional cases may be expected as wider use of nitrofurantoin continues and greater use is made of other congeners of nitrofurantoin.

The precise mechanism of toxicity is not known but depressed renal function probably represents a contributing factor and a relative contraindication to its use.

Acknowledgment: I wish to express appreciation to Dr. James T. Taguchi, Acting Chief, Medical Service, Veterans Administration Center, Dayton, Ohio, and Clinical Assistant Professor of Medicine, Ohio State University, Columbus, Ohio, for his encouragement, constructive criticism and advice.

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CARBOHYDRATE TOLERANCE IMPROVED or become normal in 13 of 14 young, nonobese, mildly diabetic patients who were treated for 2 to 22 months with tolbutamide. These patients ranged in age from 11 to 35 years, and the usual dosage of tolbutamide was 0.5 Gm. twice a day. The results cannot be explained on the basis of spontaneous improvement of carbohydrate tolerance, since in several patients diminished carbohydrate tolerance was stable or becoming more severe before the drug was started. Observations in several patients showed that dietary changes by themselves were not responsible for the improvement of glucose tolerance. That increased secretion of insulin was the mode of action of tolbutamide in these patients was suggested by normalization of the response to a glucose load as well as the occasional occurrence of fasting and postprandial hypoglycemia. Furthermore, the finding of postglucose hypoglycemia suggests that the initial defect in the young as well as in the middle-aged diabetic may be failure to release insulin quickly in response to hyperglycemia.

These studies could have an important bearing on the problem of prevention of diabetes mellitus. Asymptomatic diabetes was first diagnosed in 13 of the 14 subjects of this series when routine glucose tolerance tests were performed because of a strong family history of diabetes. Experience in this group suggests that, if decompensation of islet cell function in young mildly diabetic patients is to be prevented, diabetes must be discovered and treated at a time when islet cell function can still be materially augmented. — *Abstract:* Stefan S. Fajans, M. D., and Jerome W. Conn, M. D., Ann Arbor, Mich.: Tolbutamide-Induced Improvement in Carbohydrate Tolerance of Young People with Mild Diabetes Mellitus. *Diabetes,* 9:83-88 (March - April) 1960.

# Vascular Invasion in Rectal Carcinoma

## An Indicator of Probable Distant Metastasis and a Deterrent of Radical Surgery. A Case Report

JEROME GROSS, M. D.

AN EXTENSIVE surgical procedure for the treatment of malignant disease is properly reserved for those patients for whom there is a prospect of cure. Only under exceptional circumstances is a radical procedure, purely for palliative purposes, justified. The duration and extent of the tumor, the age and physical condition of the patient, the existence of local invasion or metastasis to lymph nodes, and the degree of malignancy of the tumor all must enter into the decision to perform a radical excision. One absolute contraindication to such a procedure is the presence of distant metastases which cannot also be completely excised or treated successfully by any other means. Unfortunately, the presence of distant metastases is not always detected so that, at times, needless radical operations are performed. The following case points up this problem.

### Case Report

A white woman 52 years of age was admitted to the hospital with the complaint of nausea and vomiting of one week's duration. There had been no abdominal pain. Recently, there had been constipation that was relieved by enemas. There had been no diarrhea at any time, and there was no history of the passage of blood in or with the feces.

The general physical examination was not remarkable, except for a very large rectocele, some external and internal hemorrhoids, and a small, firm, polypoid, roughly spherical nodule about 0.5 cm. in diameter in the rectum close to the anus. The nodule appeared to be an organized thrombosed hemorrhoid. There was no enlargement of any of the superficial lymph nodes. The abdominal examination revealed nothing abnormal. A small ulcer in the duodenum was diagnosed by x-ray.

With abeyance of symptoms, and with the patient in good fluid and electrolyte balance, a repair of the large rectocele was performed, and, at the same time, the nodule in the rectum was widely excised. In the gross, the nodule appeared to be a sessile polyp about 0.5 cm. in diameter and covered by somewhat friable mucosa. It had a short, wide pedicle. Because of the possibility of malignancy, the hemorrhoidectomy which was planned was not performed.

Submitted April 18, 1961.

*The Author*

● Dr. Gross, Cleveland Heights, is a member of the active surgical staffs of the Mt. Sinai and Woman's Hospitals of Cleveland, and member of the courtesy staff of St. Luke's Hospital, Cleveland.

The pathologic report was "Adenocarcinoma, highly undifferentiated, of large bowel, showing vascular invasion." Microscopically, the sections showed masses of neoplastic cells not only within lymphatics but also within small and large veins as well as in some greatly dilated capillaries containing blood (Fig. 1).

Several days, later at laparotomy, no free fluid was present in the peritoneal cavity, and there were no palpable lymph nodes in the mesentery. The liver, of normal size and smooth surface, presented no obvious metastatic nodules, but palpation revealed variable resistance of the tissue and a nodular consistency, although no granularity was actually visible. Since it is generally recognized that local vascular invasion exhibited by a malignant tumor greatly enhances the

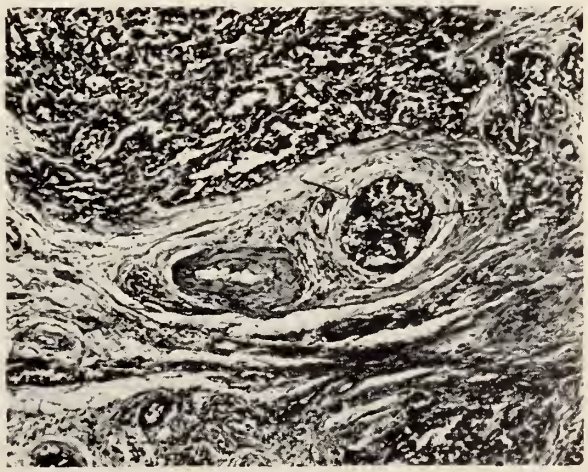


FIG. 1. *Photomicrograph of anorectal tumor showing vascular (venous) invasion. Hematoxylin-eosin stain. X100 (See arrows).*

probability of early distant metastasis, such spread to the liver was considered very likely in this case. Therefore random specimens were taken at various sites where abnormal consistence of the tissue was felt and immediate frozen section was carried out. Only the sixth of successive specimens disclosed a definite small nest of adenocarcinoma. Later, paraffin sections confirmed the diagnosis of microscopic nodules of metastatic adenocarcinoma (Fig. 2).

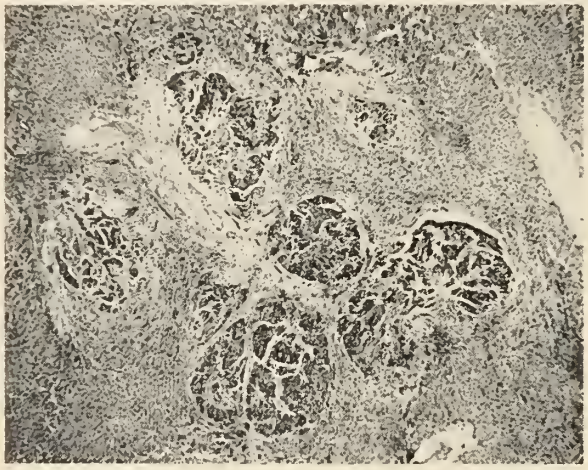


FIG. 2. *Nodule of metastatic adenocarcinoma in liver. Hematoxylin-eosin stain. X50.*

Because of the demonstration of metastatic disease in the liver, the original intention of performing colostomy and abdominoperineal resection of the rectum was abandoned. Although the patient left the hospital in fairly good condition, her prognosis was obviously poor. Four months after the operation, she was deeply jaundiced because of extensive involvement of the liver by tumor growth, but fecal elimination was unimpaired, and, at the time of death shortly thereafter, there was still no sign of local recurrence at the site of the excision of the rectal nodule. It is probable that not only the vascular invasion but also the location of the tumor at the anorectal junction and the mechanical effect of defecation on the tumor determined the early metastasis.

This case demonstrates that, properly alerted by the pathologist, the surgeon should persist in a search for distant metastasis before subjecting a patient to a radical and mutilating operation, and it also illustrates the fact that even the small size of a tumor does not preclude the existence of distant metastases.

## Summary

A case is reported of a small, polypoid adenocarcinoma at the anorectal junction with metastasis to the liver in a patient with no symptoms attributable to the local tumor and no indication of metastasis. A small, polypoid nodule, ostensibly an organized, thrombosed hemorrhoid, proved to be an adenocarcinoma exhibiting pronounced local vascular invasion. Subsequent laparotomy and immediate examination of frozen sections of six successive specimens of the liver finally revealed microscopic nests of carcinoma. The colostomy and extensive abdominoperineal resection, which had been planned, were therefore not undertaken. This case emphasizes the possibility that even small tumors may exhibit early distant metastasis by virtue of blood vessel invasion and the great importance of a careful examination for metastasis before any extensive surgical procedure is undertaken for the treatment and possible cure of a malignant growth.

**Acknowledgment:** The writer is indebted to Dr. Harry Goldblatt for microscopic examination of the original tumor and to Dr. Bruce Andreas for examination of the frozen sections of the biopsy specimens of the liver.

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GENETIC APPROACHES TO COMPREHENSIVE MEDICINE.— Gene mutations create for us biochemical irregularities which we cannot, for the most part, simulate in the laboratory. Elucidation of the problems which emanate from these experiments of nature have great significance in the understanding of normal human chemistry. It is suggested that the lessons to be learned about molecular mechanics from the study of genetic diseases will be invaluable as guide-posts in that fast aproaching era when many nongenetic disorders will be attacked at the submicroscopic level.

For these reasons the importance of even the rarest inborn error should not be measured by the proportion of first admissions for which it is now, or ever will be, responsible. — L. Pinsky, Montreal, Canada: Genetic Approaches to Comprehensive Medicine. III. Molecular Pathology. *McGill Medical Journal,* 29/1: 23-32 (February 1960).

# Long-Term Anticoagulant Therapy

GEORGE MORRICE, Jr., M. D.*

THE Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

**In what disease states is long-term (over one month) anticoagulant therapy indicated?** Intractable angina pectoris, intermittent cerebral ischemia due to carotid or vertebral-basilar artery atherosclerosis, recurrent myocardial infarction, recurrent pulmonary emboli, recurrent thrombophlebitis, and peripheral embolization from rheumatic heart disease. In those coronary artery disease patients who have had no complications after being on anticoagulants for one or two years, one might discontinue this medication with relative safety if further studies bear out recent statistics.

**Which oral anticoagulant is preferred above all others?** Any one of the available prothrombinopenic agents, properly handled, is satisfactory for routine use in anticoagulant therapy. A therapeutic prothrombin level can be somewhat more rapidly achieved with diphenadione (Dipaxin®), anisindione (Miradon®), phenylindanedione (Hedulin®) and warfarin (Coumadin®) than with bishydroxycoumarin (Dicoumarol®), but this has little practical advantage.

**At what prothrombin level should ambulatory anticoagulant patients be maintained, and how often should they be tested?** Many physicians experienced in this form of therapy prefer a Quick prothrombin time, 1½ to 2 times the control time. Thus the prothrombin activity is not as depressed as with short-term hospitalized patients. Tests should be obtained at intervals of one, two, three, or at the most four weeks. When stopping these drugs after prolonged therapy, it is perhaps wise to taper the dosage down gradually to avoid the possibility of a "rebound hypercoagulable state."

**What are the contraindications to the use of anticoagulant therapy?** Absolute contraindications are bleeding states (gastrointestinal, central nervous, and genitourinary systems), myocardial infarction with hemorrhagic pericarditis, a significant hypoprothrombinemia evident on the pre-treatment test, any hemorrhagic diathesis, and recent operations on the brain or spinal cord. Relative contraindications are severe diasotolic hypertension (pressure over 120 mm. of mercury), renal or hepatic insufficiency, tube drainage of stomach, small intestine, or urinary tract, and personality disorders. Patients who are unreliable, should not be placed on ambulatory anticoagulation therapy. These drugs should be given cautiously, if at all, to women in the third trimester of pregnancy.

Physicians who do not have dependable laboratory facilities should not use these drugs. The attending physician or his alternate should be continuously available to the patient.

**How can hemorrhage occur in a patient who appears to be within the therapeutic range of prothrombin times?** Other sources of hemorrhage may be present, such as cancer, ulcer, diverticulitis, polyps, and renal calculi. Furthermore, there may be a disturbance in other blood clotting factors such as factor VII, factor IX (Christmas factor), or factor X (Stuart-Prower).

**What factors would cause increased prothrombin time response to anticoagulants?** Hepatic disorders; vitamin $K_1$ deficiency of obstructive jaundice, steatorrhea and infectious hepatitis; poor nutritional state; diarrhea; high fever; collagen disease; congestive heart failure; visceral carcinoma, particularly of pancreas.

*Exogenous factors* would be salicylates in excess of one gram per day; phenylbutazone; sulfonamides; antibiotics (penicillin, chloramphenicol, chlortetracycline); alcohol; diet low in protein, vitamin C, choline, or cystine; prolonged narcotics; prolonged hot weather; drugs affecting blood elements, such as quinine; hepatotoxic drugs; and anesthetics.

**What further can be done to protect patients on ambulatory anticoagulant therapy?** These patients should be thoroughly grounded in the reason for this type of therapy, the medications they are receiving, the size of tablets available, their current dosage, and emergency measures which might be necessary. They might also be given anticoagulant wallet cards (available from your local Heart Society Office).

*Dr. Morrice, Columbus, is a member of the attending staffs at Grant, Riverside Methodist, and Mt. Carmel Hospitals; assistant clinical professor of Medicine, The Ohio State University College of Medicine.

# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

HORACE B. DAVIDSON, M.D., *President*

### *Presented by*


- Howard D. Sirak, M.D., Columbus, and
- Emmerich von Haam, M.D., Columbus.

Edited by Dr. von Haam.


PRESENTATION OF CASE

A WHITE male boiler operator was first admitted to Ohio State University Hospital at the age of 53 years. At 30 years of age he had had swelling and pain in both knees and shoulders. The joint pains lasted approximately two years with remissions and exacerbations. For four to five years prior to his first admission he had had frequent upper respiratory infections and developed asthmatic wheezes, orthopnea, and increasing shortness of breath.

He entered the hospital because of left chest pain of four to five months' duration. Physical examination at that time showed an irregular pulse with a rate of 96 per minute and occasional coarse rhonchi in the lungs. His heart was enlarged and there were many extrasystoles. A grade 2 aortic systolic murmur and a grade 2 apical diastolic murmur were heard. There was no presystolic accentuation. Cardiac fluoroscopy with barium swallow revealed an enlarged left atrium. The aorta showed good pulsations. The electrocardiogram showed right ventricular and atrial enlargement. The venous pressure was 135 mm. of water. A mitral commissurotomy was performed. The opening of the mitral valve was found to be 0.5 cm. in diameter and it was widened to approximately 2.5 cm. The left atrial pressure prior to commissurotomy was 45 over 32 and after commissurotomy it was 20 over 9; the pressure in the pulmonary artery was 64 over 40 prior to commissurotomy and 56 over 24 afterwards.

### Readmissions

After recovering from surgery the patient returned to his work as boiler operator but after two weeks he began to have edema and increasing dyspnea on exertion and developed periods of cardiac failure following upper respiratory infections. He was readmitted to the hospital several times with atrial fibrillation which was successfully treated with quinidine. After three and a half years he became intolerant to the drug and had to stop working. Readmitted to the hospital, he complained of recurrent bouts of dizziness, syncope, blurred vision, and frequent headaches. His breathing capacity was 44.8 per cent of normal. His appetite was poor and he gradually lost weight. He complained of tightness across his chest. His blood pressure was 130 over 80, his pulse rate 150 to 160 per minute, his respirations 22 per minute. On chest x-ray his heart was slightly enlarged; the left atrium was enlarged but appeared smaller than it was before the operation. The vascular pattern of the lungs was slightly increased. Electrocardiograms showed atrial fibrillation, left ventricular hypertrophy, and inverted ST-T wave changes, some of which may have been due to digitalis. His major trouble was considered to be myocardial disease.

Submitted October 31, 1961.

### Tenth and Final Admission

On iodine derivatives, digitalis and Diuril® he did fairly well until two weeks prior to his tenth and final admission, five years after his commissurotomy. During the last two weeks he suffered from weakness, dyspnea, orthopnea, and cough productive of frothy white sputum. For the past two days he had noted sore throat, fever, chills and soreness of the neck. He denied hemoptysis or purulent sputum.

### Physical Examination

The patient was a well developed, poorly nourished, 58 year old white man who appeared acutely and chronically ill and was in acute respiratory distress. His temperature was 101°F. rectally, his apical pulse rate 140 and the radial pulse rate 80 per minute and irregular, the respiratory rate 30 per minute and his blood pressure 122 over 80. The fundi of the eyes showed grade 1 arteriosclerotic changes. The chest was symmetrical with an increase in the anteroposterior diameter. The lungs revealed diffuse wheezing and rhonchi during the expiratory phase; moist rales were heard at the bases posteriorly. The heart revealed atrial fibrillation. The apex was in the sixth intercostal space in the anterior axillary line; a grade

2 systolic murmur was heard. An opening snap was audible at the mitral valve, and a questionable grade 2 crescendo type diastolic murmur could be heard at the apex. No organs or masses were palpable in the abdomen. The extremities showed no edema.

### Laboratory Data

The hemoglobin was 13.8 Gm., the hematocrit 45 per cent, the sedimentation rate 20 mm. (corrected); the white blood cell count was 9,000 with 65 per cent neutrophils, 34 per cent lymphocytes and 1 per cent monocytes. The urine was normal. The blood sugar was 130 mg./100 ml. The $CO_2$ combining power was 32 mEq./L.; the serum sodium was 147 mEq., the potassium 3.5 mEq. and chlorides 103 mEq./L. Transaminase determinations showed 31, 40, 56, 58 and 46 units. Blood cultures were negative. Culture of the sputum grew out a rare beta hemolytic *Streptococcus*. Smears for acid-fast organisms were negative. The anti-streptolysin O titer was 100 units. C-reactive protein was 3 plus.

The electrocardiogram was recorded as showing atrial fibrillation, complete right bundle branch block, left ventricular enlargement and probable combined ventricular enlargement, and some myocardial changes possibly due to digitalis. X-ray films of the chest showed moderate cardiomegaly with pulmonary vascular engorgement and bilateral pleural effusion.

### Hospital Course

Twenty-four hours after admission the patient was still febrile and his apical pulse rate was 140 per minute. Clinically he improved. He became afebrile by the fifth hospital day. The next day the chest film was reported to show slight decrease in the heart size, but the pulmonary engorgement and the pleural effusion were still present. On the same day he suffered a sudden episode of dyspnea followed by cessation of pulse and respirations. Resuscitation attempts were unsuccessful.

## CLINICAL DISCUSSION

DR. VON HAAM: Sometimes a clinicopathological conference is chosen to discuss diagnostic problems, sometimes because it presents a rare medical case, and sometimes it is chosen in order to introduce a specific field for general discussion. I don't think the diagnosis was any problem in this patient, who died five years after apparently successful heart surgery. I hope that Dr. Sirak will use this case to discuss all the advantages, disadvantages, dangers and contraindications for heart surgery.

DR. SIRAK: From the history of this patient we get a pretty good indication that this is a case of chronic rheumatic heart disease. He was in the hospital 10 times and gave a history of rheumatic-like pains since the age of 30. We note from the physical examination at the time of his first admission that he was fibrillating. From the fact that he had an aortic systolic murmur we would surmise that he had an aortic stenosis, and from the apical diastolic murmur that he had a mitral stenosis. The history does not state that there was no diastolic aortic murmur heard, although patients sometimes do have aortic insufficiency, which may not be heard, accompanying their aortic stenosis. The cardiac fluoroscopy after barium swallow was interpreted as an enlarged left atrium, which would certainly be compatible with mitral stenosis. We are left to presume that there was no evidence of any ventricular enlargement at this time or else it would have been reported here.

### Elevated Venous Pressure

"The aorta showed good pulsations." This may mean a normally expansile aorta or that the expansile activity of the aorta was exaggerated. In a person with aortic insufficiency, in which there is an increased amount of blood thrust back into the aortic root during every diastole, the aorta would demonstrate an increased expansile activity. This might well have been present in this person with aortic stenosis, the murmur being missed or masked by the systolic murmur. The venous pressure gave a reading of 135 mm. of water, which is essentially within normal limits. The venous pressure is dependent upon the right atrial pressure which in turn is a function of the diastolic pressure of the right ventricle, and that pressure is an indication of the thickness of the right ventricle. A thicker ventricle is less pliant and it takes more pressure in the right atrium to fill it during diastole. So a person with a hypertrophied right ventricle would have a higher venous pressure than an individual with a normally pliant right ventricle. We would expect this patient to have right ventricular hypertrophy in the presence of mitral stenosis. The electrocardiogram showed predominantly right ventricular hypertrophy compatible with mitral stenosis.

### Significance of Aortic-Valve Lesion

We know also that this patient had an aortic murmur, which means that he had an aortic lesion. What we are really worried about is whether this aortic stenosis lesion, which was not thought to be functionally significant before the mitral valve was opened, will prove functionally significant after the mitral valve was opened. If you open the mitral valve you increase the amount of blood being rushed through the aortic valve and any aortic valve lesion may become functionally significant. So today, the individuals who are considered optimal cases for mitral commissurotomy are those who have pure mitral stenosis. Obviously, if you increase the amount of blood in the left ventricle it is going to exaggerate the significance of the aortic valve lesion. Similarly, if the patient has mitral insufficiency in association with his mitral stenosis, you very likely will exaggerate the mitral insufficiency by the commissurotomy as well.

Now the pressures taken at the time of operation,

before and after commissurotomy, showed a reduction in the pressure in the left atrium after commissurotomy. This indicates that they got a good mitral commissurotomy and I have no reason to doubt that they did. However, this must be taken with a grain of salt. We don't know what the cardiac output was at each of these two times. Obviously if you have an orifice which is 2 cm., 1 cm. or 0.5 cm. in diameter and you are putting 3 liters through it, it is a great deal different from trying to put 5, 6 or 7 liters through the valve opening. So the actual measurement of pressures alone does not tell you unequivocally what is happening to the orifice at the valve itself. Pressures were taken in the pulmonary artery as well. The pressure in the pulmonary artery is a function of the resistance of the mitral valve and of the small muscular arteries in the lung. Medial hypertrophy and intimal proliferation may occur in the small muscular arteries in response to an increased pressure in the pulmonary bed as a result of a block at the mitral valve, and this may lead to a higher pressure in the pulmonary artery than in the left atrium.

### Transient Improvement, Then Heart Failure

After the commissurotomy the patient did better. He did better because they removed the block from the mitral valve, which reduced the pressure in the entire pulmonary vascular bed. It reduced the rigidity of the lungs, increased the pliability of the lung so that it was easier for the patient to breathe, and it also increased his cardiac output. The patient returned to work. He had two weeks of relief but he came back into the hospital with syncope and dyspnea and evidence of heart failure. His blood pressure at one of his later admissions was 130 systolic, 80 diastolic. I don't know whether this is an indication of aortic insufficiency or of his fast pulse, but we have to keep in mind again that perhaps the aortic lesion, aortic stenosis and perhaps aortic insufficiency, was now becoming manifest. The electrocardiogram showed left ventricular hypertrophy suggesting that now the left ventricle was taking a beating from having to cope with the increased amount of flow through his improved mitral valve.

### Persistent Diastolic Murmur

His physical examination at his last admission, five years after his heart surgery, tells us that he was in heart failure with a temperature of 101°. I have no reason to believe that he had bacterial endocarditis although he might have had it. We have no positive blood cultures to prove that. They did hear at the mitral valve a grade 2 systolic murmur and a remaining diastolic murmur. Now the presence of this diastolic murmur does not necessarily mean that he had an inadequate mitral commissurotomy. The valve leaflets were without doubt abnormal; they did not open and get out of the way completely and there would be turbulence around them, so it is not unreasonable to assume that one would hear some murmur on this basis. Whether it was functionally significant or not I cannot tell from this protocol. I think of considerable interest is the fact that he now had a mitral systolic murmur as well. So he now had an additional load on his left ventricle on top of his aortic valve lesion, which could throw his left ventricle into failure.

### Concentric Hypertrophy In Aortic Stenosis

The heart size radiographically had not changed a great deal. I think you would not expect to see a great big heart in this patient unless the heart had been in frank failure and stayed in frank failure. It seems to me that this man went into failure, got a little rest, got back into shape again, was compensated and stayed that way for a time. But he seemed to be able to get himself in and out of failure from time to time, perhaps not completely. The reason the x-ray showed concentric hypertrophy of this left ventricle was that it was working against his aortic stenosis. If this were a wide open insufficiency, where you have an increased cavitary size of the ventricle to accommodate the reflux of blood, then you would see a much larger heart shadow. In patients with aortic stenosis, on the other hand, it is common to see a normal or only slightly enlarged heart shadow.

### Myocarditis?

I don't think we can ascribe this to myocarditis. Medical people know more about this than I do, but it is my impression that a person with myocarditis and failure has a dilated heart, and we just don't see that in these x-rays. I don't get very much out of his laboratory tests. Nothing seemed greatly abnormal. The hospital course showed that the patient improved clinically. His repeat chest film showed that he had a decrease in heart size. He then died after a sudden episode of dyspnea followed by cessation of pulse and respirations. I think this is not an uncommon death for a man who has a significant degree of aortic stenosis, from which patients die suddenly.

### Thorough Preoperative Evaluation Essential

I think we might mention several things which, from the surgical point of view, we would do differently today. First, I think patients who are suspected of having mitral stenosis should be more thoroughly evaluated, particularly with regard to associated valvular lesions. In order to differentiate aortic insufficiency from pulmonic insufficiency, which may accompany mitral stenosis but has a considerably different significance as far as prognosis and management are concerned, we now do retrograde aortagrams so that we may observe the reflux of dye back into the left ventricle. In patients who have aortic systolic murmurs or aortic stenosis we now do atrial punctures. We put a catheter into the left atrium

through the mitral valve and measure the pressure in the left ventricle. At the same time, you can measure the cardiac output so that you can then estimate how functionally significant an aortic stenotic lesion is.

I would have to say in the light of present-day management that this patient should not have been subjected to mitral commissurotomy on the basis of the information that was present. He should have the diagnostic evaluation that we mentioned and, if he had significant aortic valve disease, it would have been necessary that one repair both the aortic and the mitral valve at the same time. This is a more formidable undertaking. The surgery of acquired aortic valvular lesion is progressing, but it has not yet solved all problems. It requires, in the majority of cases, prosthetic replacement of the aortic valve leaflets or of the entire valve. This is in the process of development and I think this patient would certainly be a candidate for that type of surgery: using the heart pump, doing a mitral commissurotomy under the direct vision and then going up to the aortic valve and replacing it, thus correcting him physiologically in both areas. I think it is essential in these people with involvement of both valves that they have surgical treatment to both valve areas and not to just one. Otherwise, if you operate only on the mitral valve, you trade a right ventricular for a left ventricular problem at some later date.

### CLINICAL DIAGNOSIS

1. Old rheumatic heart disease.
2. Aortic stenosis with acute heart failure.
3. Mitral stenosis.
4. Status five years post-commissurotomy.

### PATHOLOGICAL DIAGNOSIS

1. Rheumatic heart disease.
   (a) Mitral stenosis and insufficiency.
   (b) Aortic stenosis.
2. Pulmonary hypertension with cor pulmonale.

### PATHOLOGICAL DISCUSSION

Dr. von Haam: Thank you very much. I think the main question here should be put this way: Did we do the patient good or did we do him harm with surgery? And second, if we did not do any good, what were the circumstances responsible for the poor success of this patient's operation?

At autopsy, we found really not much evidence of acute heart failure. The heart weighed 375 Grams, which is not a very large heart. There was no edema, there was no free fluid, such as hydrothorax or ascites. As we opened the heart and looked through the left atrium into the mitral valve we saw severe stenosis of the mitral valve which permitted only the tip of the finger to enter. It measured 1.1 cm. in diameter. The mitral valve before surgery measured 0.5 cm. in diameter. At surgery they opened it up to a diameter of 2.5 cm., and five years after surgery this valve had shrunk again to a width of 1.1 cm.

The aortic valve was stenosed, calcified, and somewhat fibrotic. It measured 4 cm. in circumference and permitted the first phalanx of the index finger to pass through. It was not what we would call severe stenosis; it was not as much stenosed as the mitral valve, but it was definitely stenosed. The cusp toward the mitral valve side showed severe calcification. The section of the mitral valve showed changes which are undoubtedly evidence of old rheumatic heart disease. Section through the aortic valve showed similar changes of this type. There was a large calcified plaque which showed pseudobone formation. It is these plaques which we found pressing upon the myocardium which explain the sudden death of patients with severe calcific aortic stenosis.

### Active Rheumatic Inflammation

I think some explanation of this patient's condition is best demonstrated by the deposition of a peculiar acidophilic substance that represents evidence of active rheumatic heart disease. It was a new deposition of fibrinoid substance upon the much thickened leaflets of the mitral valve, which explains that the patient's rheumatic valvular disease was continuing during the five years after surgery. As we studied the myocardium we found it amazingly free of inflammatory lesions. However we did see myocardial scars that had the typical perivascular arrangement of old healed rheumatic myocarditis. There were only relatively few foci of focal myocarditis of the type which is not specific for rheumatic disease but which we can find in numerous conditions such as viral infections.

Examination of the operative site showed adhesive pericarditis and a fibrous scar in the left atrium. The patient's right ventricle showed a thickening to 7 mm., indicating persistent pulmonary hypertension, probably the effect of his mitral stenosis. Examination of the lung showed marked thickening of the walls of the middle-sized pulmonary vessels with duplication of the elastica and some pulmonary fibrosis. There was also some evidence of small pulmonary infarcts which had healed with fibrosis. Small granulomas of the Wegener type were also found indicating that the patient's allergic status still persisted. This also seems supported by the presence of increased (3 plus) C-reactive antibodies in his blood.

*In conclusion*, I feel that the patient had persistent rheumatic fever which partially nullified the success of his operation and produced recurrent mitral stenosis with pulmonary hypertension, and that he had aortic stenosis as an aggravating condition. I believe that the sudden death of the patient was not due to myocardial failure but was probably caused by sudden cardiac arrest described so frequently in aortic stenosis. Dr. Sirak, can you tell us how often we see

the re-formation of the rheumatic mitral stenosis after surgery? Should this patient have been treated for rheumatic fever after his operation or was it correct to forget all about his rheumatic fever?

### General Discussion

DR. SIRAK: Patients who have rheumatic valvulitis should always be on prophylactic penicillin 1,200,000 units (or its equivalent) by injection once a month. Some people feel that a gram a day of sulfadiazine is adequate prophylaxis. As far as re-fusion of the mitral valve leaflets is concerned, I think this undoubtedly does occur. I am not trying to say that an inadequate valvulotomy was or was not done. One thing is certain: if you have very stiff leaflets which are fibrotic and thickened so that there is not much mobility in these leaflets, then there is no question but that re-fusion can and does occur. Certainly if the patient had recurrent rheumatic fever and was not on prophylactic penicillin the chances for this to occur were markedly increased.

### Pulmonary Hypertension And Sudden Death

DR. J. M. RYAN: I don't think the aortic stenosis was particularly pronounced. I wonder if the cause of his sudden death was not the pulmonary hypertension and fibrosis of his lung? This is not uncommon. These patients suffer the same sort of death as those with aortic stenosis. As far as prophylaxis goes, we still question its value. Active rheumatic disease at this man's age is certainly not very common. I agree with Dr. Sirak that it is hard to say that this was not an adequate valvulotomy. We think re-fusion does occur, but I think in most hearts where we see re-fusion it is probably due to an inadequate valvulotomy done by the blind technique.

## Franklin County Pelvic Cancer Delay Committee Report

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee at its regular monthly meeting held on October 18, 1961.

Case Number 96: In 1958, this 69 year old white woman sought medical attention because of lower abdominal pain, enlargement of her abdomen, and vaginal bleeding. Examination by a physician revealed an irregular mass filling the pelvis. At laparotomy the diagnosis of right ovarian carcinoma was made. A total hysterectomy with bilateral salpingo-oophorectomy was performed. Her subsequent course was without complaints until the onset of her present illness one month ago. At this time the patient complained of vaginal spotting, and a cul-de-sac mass was discovered on pelvic examination by her family physician. The diagnosis of recurrent pelvic carcinoma was facilitated by a needle aspiration biopsy through the posterior cul-de-sac. The patient is now receiving a full complement course of external irradiation for recurrent ovarian carcinoma, utilizing rotational Cobalt-60 teletherapy.

### Comment

All physicians concerned in this case are to be congratulated for acting promptly when presented with the diagnostic triad of ovarian carcinoma and again when the first sign of recurrence appeared. When postoperative external radiation is omitted in the therapy of ovarian carcinoma, particularly when capsular penetration or pelvic peritoneal contamination has occurred, then criticism is order. Recurrent pelvic carcinoma secondary to ovarian carcinoma is best prevented by the use of postoperative external irradiation. This will subsequently increase the five year survival rate of this disease.

*Delay:* No physician delay.

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ASIAN INFLUENZA DURING PREGNANCY.— A severe epidemic of Asian influenza occurred in Helsinki (Finland) in Oct. - Nov. 1957 (morbidity c. 32 per cent). Subsequently, between Jan. 15 and Oct. 31, 1958, the material from a maternity hospital was examined with special reference to congenital anomalies.

The authors state their study permits the conclusion that influenza is no teratogenic agent in the same sense as rubella, in which the virus is assumed to cause direct damage to the foetus (it may be added here that viremia is unknown in influenza). It appears evident, however, that after an epidemic of this kind there is an increase in the incidence of foetal anomalies — an observation that we are inclined to attribute to possible associated factors, such as high fever, complications, intensive medication, or perhaps to some toxic metabolites as suggested by Coffey & Jessop (1959). This supports the opinion that various external factors are involved also in human teratogenesis.— *Abstract:* Saxén, L.; Hjelt, L.; Sjöstedt, L. E.; Hakosalo, J., and Hakosalo, H., Helsinki: *Acta pathologica et microbiologica Scandinavica,* 49/1:114-126 (1960).

# Maternal Deaths Involving Rare Hemorrhage

By the OSMA COMMITTEE ON MATERNAL HEALTH

DURING the past five years, through this column of *The Journal,* various cases involving obstetric "hemorrhage" have been presented from time to time. Usually, these include specific categories, such as abruptio placenta, placenta previa, etc. Herewith, the Committee is privileged to present four maternal death cases involving hemorrhage of most unusual, practically rare, etiology.

## Case No. 260

This patient was a 34 year old white, Para IV, who died 11 hours postpartum. Eleven years before, she had a cholecystostomy; otherwise, her past history was not remarkable. There were three previous term pregnancies, details of which are not reported. With her last menstrual period July 19, the patient (apparently) proceeded without complication (?) until March 15 (eighth month), when she was brought into the hospital by the police in a state of coma. Medical, obstetrical and surgical consultation were obtained at once. Transfusions were started, a diagnosis of severe internal hemorrhage was made, and a laparotomy was performed at 9 p. m. The peritoneal cavity was "full of blood and clots"; the uterus was opened (low cervical) and a dead fetus was extracted. The source of the hemorrhage could not be found; another surgeon "scrubbed in" and he was unable to find the bleeding point; also, with transfusions going, the abdomen was closed. Details are lacking, but the records indicate a recurrence of the bleeding eight hours later. A second laparotomy was performed in a fruitless effort to find the bleeding vessel. The patient died, with source of the hemorrhage unexplained. A total of 12 units of blood had been given. An autopsy was done.

*Pathological Diagnosis:* Total hemoperitoneum; ruptured aneurysm of the splenic artery.

### Comment

With a profound sense of awe, the Committee studied available facts in the case. Members wondered why a low cervical cesarean was chosen in preference to a classical one. The cause of rupture of the aneurysm was obscure, without a history, including trauma; no member had ever heard of a similar case, but sensed the dilemma which must have enshrouded the operating surgeon. The case was voted a nonpreventable maternal death, unavoidable catastrophe.

## Case No. 268

This was a 37 year old white, Para IV, abortus II, cesarean I, who died three days postoperative (postpartum). She was known to have had latent syphilis and there was a dilatation and currettage for an early incomplete abortion three years before. Four previous term pregnancies were recorded without complication; one was a 10 pound breech delivery. Two spontaneous abortions are reported, one completed by curettement. With her last pregnancy the patient registered in her third month, but made only two more prenatal visits; the last one was near term, when a diuretic was prescribed. Specific details are lacking, but in her tenth month (?) labor was induced by "stripping the membranes," which finally ruptured 24 hours before delivery. The only available information indicates an emergency (low cervical) cesarean section was done under spinal anesthesia on June 27 because of "a transverse presentation." A living baby, weight exceeding 8 lbs., was delivered, whole blood being administered during and after the operation. The patient "recovered from postoperative shock," but developed ileus. On her third postoperative day the patient went into shock after arising from her bed and falling to the floor; she died promptly. An autopsy was permitted.

*Pathological Diagnosis:* Retroperitoneal hemorrhage, ruptured varices of right broad ligament.

### Comment

One member said the patient was reported to have had a postpartum psychosis and was shackled, pulled out her intravenous infusions, became violent, got up, and died shortly thereafter. To Committee members, this course of events (not recorded) served to add confusion to the perplexing problems in the case. One member asked why a low cervical section was performed to deliver a large baby fixed in a transverse lie. The records had no answer; nor could members ascertain from the available data, whether attempts had been made at first to deliver the fetus from below. Further, the narrative failed to disclose a direct or contributory reason for the "shock" which required (?) transfusions. After carefully evaluating all facts in the record, members voted this case a nonpreventable maternal death, unavoidable catastrophe.

## Case No. 430

This was a 28 year old white, gravida III, Para II, who died undelivered in her 35th week of pregnancy. Her past history is essentially noncontributory. Details in this case are very meager, but it appears she made one prenatal visit in her fifth month; findings were within normal limits. Her blood was type O, Rh. negative, with negative serology. On August 15 the patient was admitted (34 weeks gestation) apparently in premature labor. Therapy included progesterone and sedatives, which were said to be effective. On her sixth hospital day, the patient collapsed suddenly and died. Autopsy permission was obtained.

*Provisional Cause of Death:* Cardiac embolism; pregnancy; varicose veins.

*Pathological Diagnosis:* Rupture of splenic artery.

### Comment

In studying the meager facts in this case, Committee members were stunned with the tragic change in the course of the patient's smooth clinical progress. Members regretted the non-availability of a complete

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

autopsy protocol. Finally, members voted the case a nonpreventable maternal death, unavoidable catastrophe.

### Case No. 499

This patient was a 35 year old, colored, Para V, who died 43 hours postpartum. Her past history revealed only a modest anemia, and recorded presence of two uterine fibroids. There were four previous term pregnancies delivered without complication. With a last menstrual period July 17, the patient registered with her physician in her second month and made 12 prenatal visits, providing adequate prenatal care. The sole complication was ankle edema several days before delivery. At term, on April 22, the patient entered the hospital in labor, but shortly thereafter contractions ceased. Later, at 4 p. m., an attempt was made to stimulate labor by administering a dilute Pitocin® series (1 minim to 15 saline). Labor commenced, but soon ceased. Three hours later, the same stimulation was repeated, with some changes in the fetal heart rate. Seconal® gr. III was given for sleep, and labor began spontaneously at 3 a. m. April 23. Progress was rapid and soon an 8 pound fetus was delivered by low forceps, no laceration, no episiotomy.

The third stage was reported normal with blood loss of 100 cc. On palpation of the uterus, fibroids were noted. No other disease was found. Six hours later, on April 23, the patient suffered moderate abdominal distension with epigastric distress and pain in the left flank. This was not relieved in two more hours. A milk and molasses enema was successful after Ilopan® was administered. At 10 a. m. the next day the patient's vital signs were normal, but there was a sharp decline in the hematocrit and hemoglobin. By 11:30 a. m. the pulse rate rose and the blood pressure fell, following which the patient went into shock. Consultants, ordered an hour before, considered an abdominal exploration, but felt that the patient was *too ill* to risk the surgical procedure. The patient pursued a downhill course, and died 43 hours postpartum. Autopsy was permitted.

*Pathological Diagnosis:* Ruptured aneurysm of right ovarian artery; massive retroperitoneal and intraperitoneal hemorrhage; normal postpartum uterus.

### Comment

With puzzled minds, members of the Committee studied the complete details presented in this case. Possibilities of a ruptured uterus loomed in the discussion until the autopsy findings were revealed. The contributing factors, such as a short, precipitous labor and delivery, were considered. After prolonged deliberation, the Committee voted this a nonpreventable maternal death, unavoidable catastrophe.

### Comment of Consultant

The following comment of a consultant, who is a specialist in Obstetrics and Gynecology, was furnished at the request of the Committee:

"In reviewing the above four cases, this Consultant, like Committee members, experienced a sobering sense of perplexity as the course of events developed in each report. The Committee has previously offered excellent comments from observations upon the facts which were available. However, since the information available frequently forces one to make certain feasible *assumptions* because it is incomplete or sparse, this Consultant grasps an opportunity to emphasize certain features which may be helpful in the solution of similar problems in the future, should the occasion arise.

"Case No. 260. Obviously, there was no clue as to the source of the intraabdominal hemorrhage. Consultants who were called to see the patient were equally puzzled. Like Committee members, we wonder *when* the fetus died (perhaps no relation to the maternal death) and *why* (in the face of hemorrhage) a classical cesarean was not chosen. We can compliment the surgeons for *not* removing the uterus too, in a frantic belief it might be (erroneously) contributing to the hemorrhage. In retrospect (of course) we can quote Halstead, ". . . . Never close an abdomen 'til the bleeding points are secured." The splenic artery would certainly be last to be suspected.

"Case No. 268. We concur, delivery of a large fetus, laterally presenting, through a *low cervical* cesarean incision is usually quite difficult and results in added maternal and fetal trauma. And in agreement with the Committee, this Consultant surmises that the fatal hemorrhage may have had its foundation laid during the surgical procedure which required transfusions (??) 'during and after' the operation. How much blood was required? As we read the report, we were prompted to believe the death was due to *embolism,* not to ruptured varix of the right broad ligament. We also regret that the complete autopsy report was not available.

"Case No. 430. This tragic case is one of sudden death, undelivered, after apparently good management to prevent premature labor. Varicose veins (location and state) were not mentioned on the physical examination. From a clinical aspect, the death could have been due to embolism, although no facts in the case as presented would lead us easily to suspect the direct etiology. It does support our contention that autopsies should be performed to reveal the true cause of death, otherwise obscured — 'ruptured splenic artery.'

"Case No. 499. It is possible that the ileus, six hours postpartum, was a signal of infection or blood in the peritoneal cavity, although this is only speculation in retrospect. Sudden 'collapse of the vascular system' eight hours postpartum suggests concealed (intraabdominal) hemorrhage or 'septic shock.' With a diagnosis of intra-abdominal hemorrhage, this Consultant is a bit more radical in the belief that when death is more or less imminent, the abdomen should be opened in an attempt to arrest the source of the hemorrhage! Some reader may question the use of (diluted) Pitocin and its possible contribution to the tumultuous labor which followed, all perhaps contributing to fatal rupture of the aneurysm of the ovarian artery. We feel that the time element which intervened precluded this factor as a possibility.

"Although the preceding four cases may strike a note of frustration in the mind of the reader, leading him to realize a futility associated with good care of the parturient patient, he is reminded that these (rare) cases represent only a minority of the maternal deaths in Ohio (about four in 700, the Committee advises us). It is important for physicians to encourage permission for autopsies on *all* patients whose death is related to the pregnant state! Otherwise, how could we have reviewed these interesting, baffling problems?"




# NEWS AND Organization Section

# Report of AMA Denver Session

## King-Anderson Bill, College of Surgeons Fuss, Medical Discipline Among Subjects Considered by Delegates

SOCIAL Security health care, pronouncements by the American College of Surgeons, approval of the American Medical Political Action Committee, medical discipline and polio vaccine were among the major subjects given attention by the American Medical Association's House of Delegates at the Fifteenth Clinical Meeting November 26-30, 1961, in Denver.

AMA President Leonard W. Larson, M. D., of Bismarck, N. D., keynoted the AMA's campaign to defeat the King-Anderson type of legislation in 1962, telling the opening session of the House that incorporation of health care benefits into Social Security "would certainly represent the first major, irreversible step toward the complete socialization of medical care."

### Ohio Delegates

The Ohio State Medical Association was well represented at the Clinical Meeting. Nine delegates took part in the deliberations, including Drs. George A. Woodhouse, Pleasant Hill, chairman of the OSMA delegation; John H. Budd, Cleveland; Carl A. Lincke, Carrollton; Richard L. Meiling, Columbus; Carll S. Mundy, Toledo; Charles A. Sebastian, Cincinnati; C. C. Sherburne, Columbus; E. K. Yantes, Wilmington, and Horatio T. Pease, Wadsworth, alternate seated in place of Dr. Charles L. Hudson, Cleveland, who is a member of the House ex-officio, being a member of the AMA Board of Trustees.

Dr. Walter J. Zeiter, Cleveland, attended as delegate for the Section on Physical Medicine. Dr. Charles L. Leedham, Cleveland, represented the Section on Military Medicine, as delegate.

The following Ohio delegates served on House reference committees: Dr. Meiling, Chairman, Medical Military Affairs; Dr. Yantes, Insurance and Medical Service; Dr. Mundy, Chairman, Tellers Committee.

Alternates who attended include Drs. J. Robert Hudson, Cincinnati; T. L. Light, Dayton; Robert S. Martin, Zanesville, P. J. Robechek, Cleveland; also present were Dr. Frederick P. Osgood, Toledo, who became an alternate January 1, 1962.

OSMA President George W. Petznick, M. D., and Past-President Edwin H. Artman, M. D., attended the meeting. OSMA staff members attending were: Hart F. Page, assistant director of public relations, and Charles W. Edgar, administrative assistant.

Four executive secretaries of county medical societies in Ohio were present: Mr. Robert A. Lang of Cleveland, Mr. Robert F. Freeman of Dayton, Mr. Edward F. Willenborg of Cincinnati, and Mr. S. H. Mountcastle of Akron.

### Compulsion vs. Freedom

Dr. Larson told the House that the compelling issue facing medicine is socialization versus voluntarism — or compulsion versus freedom of choice. He predicted that courage, determination, and the will to win on the part of physicians will defeat the King-Anderson bill in Congress in 1962.

The House of Delegates gave enthusiastic approval to Dr. Larson's address and took several actions reaffirming strong support for the Kerr-Mills program to aid the needy and near-needy aged, and urging a concerted, determined fight against Social Security health care proposals in Congress.

### State, County Action Advised

The House advised all state and county medical societies to recognize the impending threat and to pre-

pare now for any eventuality by continuing to oppose any scheme which tries to impose a substandard system of medical care on the American people.

"United, as well as individual, effort is essential," the House declared. "To stop short of our total effort is to invite disaster and to let loose upon our beloved America irreversible forces which will ultimately destroy her. We cannot and we must not fail."

### American College of Surgeons

The House **agreed** with the intent of five resolutions which expressed strong dissatisfaction over recent public pronouncements by a spokesman for the American College of Surgeons. Also, it **approved** a Board of Trustees report informing the House that arrangements have been made for a January meeting with the ACS Board of Regents to discuss that organization's recent pronouncements and policy positions. The report expressed hope that the meeting "will lead to a unification of effort in behalf of American medicine."

The House **instructed** the Board of Trustees to take the five resolutions to the January meeting and to report to the delegates as soon as possible on the results of the meeting. In taking the action, the House approved a reference committee report which said:

"Your reference committee believes the public airing of disagreements between large segments of medicine can only confuse and shake the confidence of the public in the medical profession and distort the true image of medicine which the American people should have.

"However, in its hearings upon the several resolutions relating to the recent statements of the American College of Surgeons, all those who testified were in opposition to the actions and statements of the ACS. The majority of those who spoke were Fellows of the American College of Surgeons.

### Obligation Cited

"Your reference committee has no wish to fan the flames of controversy ignited by the statements of the American College of Surgeons. On the other hand, the committee feels the House has an obligation to its membership — which includes physicians in all types of practice — to agree with the indignation manifested by the introduction of these resolutions and in the discussions before the committee.

"This is all the more important because the position of the American College of Surgeons is based on an incorrect interpretation of the action of this House which in no sense is a retreat from its position of firm opposition to fee splitting."

### AMPAC Approved

The House heartily **approved** the purposes and goals of the recently-organized American Medical Political Action Committee and urged all physicians, their wives and interested friends to join AMPAC and other political action committees in their states and communities.

"Effective political action must be carried on at the local level and effective implementation must be done by local groups of physicians," the House said. "The formation of AMPAC recognizes the need for a national medical political action committee to coordinate the political activities of physician groups at all levels throughout the country."

### Purposes of AMPAC

The purposes of AMPAC, which is an organization separate and distinct from the American Medical Association as required by federal law, are:

1. To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.
2. To encourage physicians and others to understand the nature and actions of their government as to important political issues and as to the records and positions of political parties, officeholders and candidates for elective office.
3. To assist physicians and others in organizing themselves for more effective political action and for carrying out their civic responsibilities.
4. To do any and all things necessary or desirable for the attainment of the purposes stated above.

### Medical Discipline

The House received from the Council on Constitution and Bylaws a proposed amendment which would have made it possible to implement a recommendation by the Medical Disciplinary Committee that was approved by the House at the June, 1961, meeting. This recommendation was to change the bylaws so as to confer original jurisdiction on the AMA to suspend and/or revoke the AMA membership of a physician found guilty of violating the Principles of Medical Ethics or the ethical policies of the Association, regardless of whether or not action has been taken against him at the local level. However, after considerable discussion on the floor of the House, the **proposed amendment was referred back to the Council on Constitution and Bylaws.**

In another action on medical discipline the House **approved** the expanded activities of the Judicial Council, which has taken over permanent responsibility in that area, and said that the Council program should benefit all physicians, the public and the profession.

### Polio Vaccine

The House **adopted** a resolution which urged that medical societies at the local, county, district or state levels throughout the United States should encourage, stimulate and participate in surveys to determine the percentage of individuals in each community who have undergone immunizing procedures for poliomyelitis.

The resolution stated that on the basis of the re-

sults of the surveys, the local medical society should determine the type of vaccine and the most effective type of program which will be of greatest benefit to the public.

Until such time as all three types of oral vaccine are available, the resolution concluded, the Salk vaccine should be the vaccine of choice for routine poliomyelitis immunization, with the choice of program for administering the vaccine to be determined on a local basis by each county medical society.

### No Resolutions Deadline

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

**Disapproved** of two proposals which would have required that **resolutions** be introduced 30 and 45 days, respectively, before Association meetings.

**Approved** a statement that physicians have an **ethical obligation** to participate in medical society activities and express their opinions fully and freely.

**Reaffirmed** AMA policy that it is not considered unethical for a physician to own or operate a **pharmacy** provided there is no exploitation of the patient.

### Drug Samples

**Agreed** with the Judicial Council that the physician himself is responsible for the control and custody of **drug samples** once they come into his possession, and in the high tradition of the medical profession he should not dispose of them in any way that could cause harm to others.

**Commended** those constituent medical societies which have moved forward in the area of **human relations** by eliminating membership restrictions based on race or color. Delegates were advised that Negro physicians now have some kind of medical society membership in every state except one.

### JCAH Probe Approved

**Approved** a recommendation that a special House committee be appointed to investigate all facets of the operation of the **Joint Commission on Accreditation of Hospitals.**

**Agreed** with the Board's choice of Miami Beach, Florida, as the site for the **1964 Clinical Meeting.**

**Approved** the combining of the American Medical Education Foundation and the **American Medical Research Foundation into the American Medical Association Education and Research Foundation,** effective January 1.

**Deferred action** on a proposed study of **fund raising** by voluntary health agencies, pending the development of additional information by the AMA Committee on Voluntary Health Agencies.

### Drug Prescribing Policy

**Reaffirmed** the previous policy that physicians should have the privilege of prescribing drugs by either **generic** or **brand name.**

**Approved** the principle of **income tax deductions** for medical care of the aged.

**Recommended,** in reviewing the **Medicare Program,** that all county medical societies in the area surrounding armed forces hospitals make a serious attempt to establish formal liaison with the physicians on those hospital staffs.

**Endorsed** the administration of indigent medical care programs developed in cooperation with local medical organizations as a legitimate activity of **state and local health departments.**

### Single Aid Program Urged

**Urged** the elimination of all "categories" in programs of **assistance to the needy** at the federal and state level, with all assistance provided through a single program.

**Referred** to the Council on Medical Service a resolution proposing the use of state and federal tax funds to provide voluntary prepayment health insurance protection for the aged. In a related action the House **approved** of experimentation with **prepayment plans** under assistance programs.

**Urged** more vigorous promotion of **voluntary non-profit prepayment health plans.**

**Urged** every physician in the United States to use automobile **seat belts.**

**Recommended,** as a civil defense measure, a **mass immunization** program for the general public.

### Group Insurance Program

**Suggested** that the Board of Trustees continue its negotiations to develop a group **disability insurance** program for AMA members.

**Concurred** in the Board's appointment of a special committee to study the organizational status of **AMA Sections,** the functions of the Scientific Assembly and existing procedures for establishing medical certifying boards.

**Instructed** the Council on Medical Education and Hospitals to study the present and potential contributions of the **American Board of Abdominal Surgery** to determine whether it should be approved as a recognized examining board.

**Approved** and commended the objectives and program submitted by the Committee for Liaison with **National Nursing Organizations.**

**Recommended** that the Secretary of Defense consider the advisability of developing a training program for **reserve medical officers.**

### AMEF Contributions

Contributions totaling $435,275.93 from physicians in six states were presented to the American Medical Education Foundation during the opening session on Monday.

Total registration for the meeting was 6,138, including 2,976 physicians.

# Increases Made in Certain Workmen's Compensation Medical Fees

INCREASES in some of the medical fees paid by the Bureau of Workmen's Compensation became effective January 1, 1962, applying to services rendered by physicians on or after January 1. Increases in the fees for first treatment at home, office, hospital, and subsequent treatments, will be of special interest to physicians.

Action increasing the fees was taken by Administrator James L. Young and the Industrial Commission upon recommendation of the Ohio State Medical Association.

### Tabulation of New and Old Fees

The following tabulation shows fees prior to January 1, 1962, and the fees which will be paid on or after January 1, 1962:

| | Prior to Jan. 1, 1962 | On or After Jan. 1, 1962 |
|---|---|---|
| First treatment at office (day) | $ 6.00 | $ 7.00 |
| First treatment, home or hospital (day) | 7.50 | 8.00 |
| First treatment, office, home or hospital (night emergency, 9 P. M. to 7 A. M.) | 9.00 | 10.00 |
| Subsequent treatment at office, including ordinary medication, dressings and intramuscular injections | 3.25 | 4.00 |
| Subsequent treatment at home, including ordinary medication, dressings and intramuscular injections | 4.25 | 5.00 |
| Subsequent treatment at hospital | 3.50 | 4.00 |
| Examination and report by specialist at request of Bureau of Workmen's Compensation | 20.00 | 25.00 |
| Intra-articular injections *(new)* | ..... | 5.00 |
| Intramuscular injections | 1.00 | *(Eliminated; see explanation below)* |
| Prothrombin test, in addition to regular treatment fee *(new)* | ..... | 2.00 |
| Electromyography-conduction velocity per nerve *(new)* | ..... | 10.00 |
| Manipulation of spine or major joints under anesthesia (does not include after-care) *Note: wording in parenthesis new* | 35.00 | 35.00 |
| Electroencephalography | 20.00 | 25.00 |
| Tendon transplant or tendon graft twice the fee for simple tendonplasty. *Note: This is new provision.* | *New* | *New* |
| Psysiotherapy by physician (not in addition to the regular treatment fee) | 3.25 | 4.00 |

It should be noted that the Bureau will not pay an extra fee of $1.00 for an intramuscular injection after January 1. When an intramuscular injection is given this service and cost of the drug are covered in the regular treatment fee. **However, in event an expensive drug has to be used by the physician for the intramuscular injection, the physician may request the Bureau to reimburse him for the cost of the drug.** This is covered in Rule No. 11 of the Bureau relating to physicians' services, reading as follows: "The fees for treatment at the office and home include ordinary medication and dressings. Additional fees for dressing materials and drugs are not approved except in fully explained cases wherein an extraordinary amount of such material or drugs is used or **expensive drugs are administered.** In such cases, the materials or drugs are paid for at cost to the physician."

The Committee on Workmen's Compensation agreed to the above change pertaining to intramusclar injections believing that usually where an intramuscular injection is given, no other services are rendered, making the regular treatment fee (which is being increased) adequate in most cases to cover the professional services and the cost of the drug.

**The fee for intravenous injection, including the cost of the medication, remains unchanged, i. e., $2.00 in addition to the regular treatment fee.**

### Consultation Rule Clarified

The Bureau and Commission, at the request of the Ohio State Medical Association, also took action to clarify Rule No. 8 of "Rules for Physicians." This rule applies to "Fee for First Service Where Consultant Continues Treatment." As now revised, Rule No. 8 reads as follows:

"In cases where the consultant continues to treat the claimant, a fee for first treatment will be paid the consultant rather than a consultant's fee unless it is affirmatively shown that the referral by the attending physician for treatment by the consultant followed the receipt and evaluation of the consultant's report. The fee for first treatment is not paid in addition to a specified flat fee."

The favorable action on the medical fee schedule followed submission of the recommendations of the OSMA's Committee on Workmen's Compensation by The Council to the Bureau in writing and conferences by representatives of the OSMA with Mr. Young and Commissioners J. Maynard Dickerson, chairman, Richard W. Tobin and Harry T. Marshall; Dr. Raymond B. Hudson, deputy administrator, Medical Section, and Homer H. Hickling, deputy administrator, Legal Section.

# Fireside Conferences Covering Cardio-Respiratory Diseases

**Thursday, May 17, 1962, Neil House Ballroom, Columbus**

THESE informal discussion groups will constitute one of the new features to be presented at the Annual Meeting of the Ohio State Medical Association, May 14-18, Columbus. The Fireside Conferences will be sponsored jointly by the Ohio State Medical Association and the Ohio Chapter, American College of Chest Physicians. Plans are to present 11 topics (listed below) at 11 round tables.

Each will have a moderator and a panel of experts. Physicians may visit any or all of the tables, asking questions and receiving comments from the panel experts. Complimentary refreshments will be served.

## TOPICS SCHEDULED FOR DISCUSSION

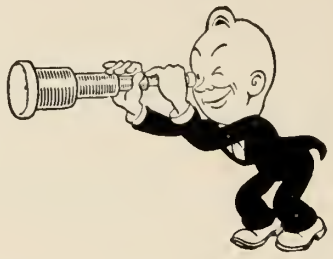
- Tuberculosis
- Chronic Bronchitis and Emphysema
- Chest Roentgenology
- Industrial Chest Diseases
- Coronary Artery Disease
- Cardiopulmonary Disability Evaluation and Work Classification
- Intrathoracic Tumors
- Cardiovascular Surgery
- Hypertension — Systemic and Pulmonary
- Rheumatic Heart Disease
- Fungus Diseases



Typical of the Fireside Conferences scheduled for the OSMA meeting are these groups shown at the recent Session of the American Medical Association. Informality is the key.

*Those Interested in These Fields Can't Afford To Miss These Outstanding Sessions*

# Looking Ahead



Reserve These Dates Now

for the

## 1962 ANNUAL MEETING OF THE OHIO STATE MEDICAL ASSOCIATION

## May 14, 15, 16, 17, and 18

## COLUMBUS

ALSO MAKE YOUR HOTEL RESERVATIONS EARLY

*Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing*

| NAME AND LOCATION | SINGLE | DOUBLE | TWIN |
|---|---|---|---|
| NEIL HOUSE, 41 S. High St. (Headquarters Hotel) | $ 7.00- 9.50 | $ 9.50-12.00 | $12.00-15.00 |
| DESHLER-HILTON HOTEL, W. Broad & N. High | $ 7.50-14.00 | $12.00-15.00 | $13.50-20.00 |
| PICK-FORT HAYES HOTEL, 31 W. Spring St. | $ 8.00- 9.50 | $11.00-12.00 | $14.00 up |
| HOTEL SOUTHERN, S. High & E. Main Sts. | $ 7.50- 8.00 | $10.00-10.50 | $11.00-12.50 |

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK
Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14-18, 1962, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Other

Arriving May.....at.....A. M.....P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

# APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1962 ANNUAL MEETING, VETERANS MEMORIAL BUILDING, COLUMBUS, OHIO, MAY 14-18

1. Title of Exhibit: .....

2. Name(s) of Exhibitor(s): .....

.....

Institution (if desired): .....

City .....

3. Do you have a built-in exhibit? .....

4. Description of Exhibit: **(Attach 200 word description to this blank)**

5. Exhibit will consist of the following: (Check which)

Charts and posters..... Photographs..... Drawings..... X-rays .....

Specimens ..... Moulages ..... Other material .....
(Describe)

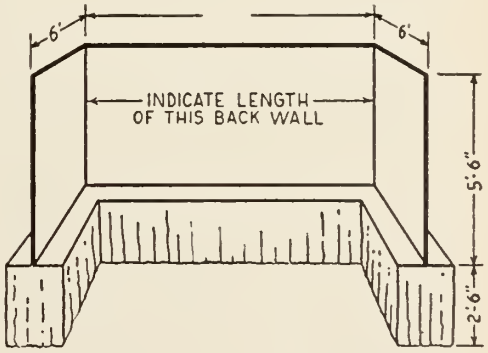
6. Booth Requirements:

Amount of wall space needed? .....

Back wall ..... Side walls .....

Square feet needed? .....

Shelf desired? (yes or no) .....




*Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.*

7. Transparency Cases:

Needed? (yes or no) .....

If answer "yes," give following information:

Number of transparencies to be shown and size of each .....

.....

.....

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association."

Date .....

.....
Signature of Applicant

.....
Mailing Address, Street

.....
City, Zone, State

**SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO. DEADLINE FOR FILING APPLICATIONS, FEBRUARY 15, 1962**

# More Family Physicians For Ohio

By THOMAS E. RARDIN, M. D., Columbus, Ohio
Chairman, Joint Committee on General Practice, O. S. M. A.
Chairman, Section on General Practice, A. M. A.

PHYSICIANS everywhere have known that the decreasing interest on the part of medical school graduates to accept the challenge of becoming family physicians and specializing in the art and science of family practice has, over the past 25 years, resulted in a great shortage of family doctors. This, despite the fact that any well trained physician — and this assumes he will have had a minimum of two years graduate preparation for family practice — can take care of at least 75 per cent of all the problems other than surgical brought to him. That this may be a conservative figure is indicated by a statement made recently by one Ohio Assistant Dean who said he believed 90 per cent of all problems brought to a physician's office could be handled by a man trained to be a highly qualified family doctor for the future.

The American Medical Association established its Section on General Practice in 1945 and has a long history of efforts and projects designed to focus attention on the Family Doctor. Some of these, like the "GP of the Year," have been misleading; however, these efforts have served to give notice that this legendary figure of old was still a most important figure in modern American medicine.

The first real study by the American Medical Association of this problem, directed by its Committee on Medical Practices, produced the Report on Preparation for Family Practice[1] in 1959 and a series of pilot two-year graduate programs designed to better prepare the family physician of the future for his duties began in July 1961. While this report concerned itself primarily with preparation of the doctor of medicine after graduation, it did, however, emphasize there is a role each medical school should assume. That role is to make certain each "Doctor of Medicine" — the basic objective of the school—graduates as a balanced doctor who understands "people with diseases" as well as just "diseases."

## Type of Practice Planned

To prove that this decreasing interest on the part of graduates to accept family practice as a way of life has worsened, year after year, one merely has to look at the statistics.

A study made by checking the class rosters of the 1955 senior class of Ohio's three medical schools against the 1961 *AMA Directory* and tabulating each man by the directory-indicated specialty showed the following:

| *School* | *Total Graduates Listed* | *General (Family) Practice* | *Spec-Teach-Research* |
|---|---|---|---|
| Univ. Cincinnati ..... | 86 | 24.4% | 75.6% |
| Ohio State Univ. ..... | 136 | 36.7% | 63.3% |
| Western Reserve ..... | 84 | 15.5% | 84.5% |

Now, in comparison, one need merely to look at the answers to the question on "type of practice planned" as given by 4,899 (72 per cent) of the 6,827 seniors in the 1959 graduating classes in 78 medical schools in the United States. These figures, taken from the Association of American Medical Colleges survey of 1959 graduates,[2] show the following:

| *General (Family) Practice* | *Specialty Practice* | *Teaching and/or Research* |
|---|---|---|
| 27% | 65% | 8% |

To focus this picture on the Ohio scene and bring it right up-to-date, I want to list the Ohio figures as shown in this 1959 survey:

| *School* | *General (Family) Practice* | *Specialty Practice* | *Teaching and/or Research* |
|---|---|---|---|
| Univ. Cincinnati .... | 38% | 54% | 8% |
| Ohio State Univ..... | 17% | 75% | 8% |
| Western Reserve .... | 18% | 58% | 24% |

No one can be sure what these 1959 graduates will be doing in 1965. It is highly debatable, however, whether Ohio State and Western Reserve could have even 30 per cent of their 1959 graduates entering family practice. The 17 per cent figure above may come as a surprise to graduates and faculty members of The Ohio State University College of Medicine, since Ohio State has always been considered and has considered itself to be a school supplying the State of Ohio with a large number of family doctors from each graduating class. In this 1959 survey, Ohio State and Western Reserve had 30 per cent fewer graduates planning a career in family practice than the national average, which was low indeed. The 21 medical schools located in the North-Central Region

of the United States had an average of 31 per cent of graduates choosing family practice. Cincinnati always has had many graduates interested in family practice and its 38 per cent placed it well above the national and regional averages of 27 per cent and 31 per cent respectively.

### Early Efforts to Solve Problem

For several years the Ohio State Medical Association, through its Rural Health Committee, has worked diligently to meet this need for more "family physicians" in the rural communities of Ohio. The traditional OSMA Special Talks for Medical Seniors, one day seminars dealing with "When You Begin Practice," have been offered students at Cincinnati, Ohio State and Western Reserve. Attendance has been voluntary. Cincinnati and Ohio State have cooperated and encouraged their students to attend these yearly seminars. No seminar is held at Western Reserve because of lack of interest.

For 13 years the Association has awarded an annual $2000 Rural Medical Scholarship, again, administered through its Rural Health Committee. This award was launched in an effort to stimulate interest in the study of medicine among young men and women in non-metropolitan areas, in the belief such students would more likely establish rural practices after graduation.

Since 1956, the OSMA through its Rural Health Committee, has sponsored also a two-week Preceptorship Program for interested senior students of Ohio's three medical colleges. The University of Cincinnati has had approximately 160 preceptees, Ohio State University has had 35 and Western Reserve has had 4.

The OSMA Rural Health Committee has gained national attention for its many projects to secure more family physicians for Ohio and is to be congratulated for its untiring efforts to improve the health of rural Ohio.

### A New Look at the Problem

Even with all these efforts, the supply of future family doctors looks bad for Ohio and the country, if present trends continue. This is not a rural problem primarily, since our urban and metropolitan areas also are short on family doctors. Much has been written about the shortage of doctors and ways to correct this shortage. These vary from government-subsidized new schools to reducing the present eight year basic program to six years and creating more two-year medical schools similar to what is being done at Dartmouth. Could it be that we are producing too many doctors to take care of too few things, when more doctors rendering "service over broad areas to people and family groups, regardless of age" might be another answer? Dr. Robert M. Zollinger, Columbus, in his recent address accepting the Presidency of the American College of Surgeons, indicated[3] an ever increasing need for a return to the broadly trained general surgeon, rather than the highly specialized, compartmentalized surgeon. Isn't this exactly what we in the area of general medicine are saying?

In an effort to meet this problem even more effectively, the Ohio State Medical Association's House of Delegates passed a resolution[4] at its 1960 meeting which, among other "resolves" contained the following:

> "2. Suggest to the Committee on Rural Health that it endeavor to develop additional ways of coping with this situation, including the establishment of Chairs of General Practice and encourage participation in preceptorship training and expansion of medical training facilities, and
> "3. Request the Committee to continue its conferences with officials of Ohio's three medical schools and seek their cooperation in additional efforts to solve this problem."

The Rural Health Committee recommended that the portion of the 1960 Resolution referring to Chairs of General Practice be referred to the Committee on Education and that a tripartite committee consisting of the Committee on Education augmented with three members each from the Rural Health Committee and the Ohio Academy of General Practice be established to take a new look at the problem. Council approved this on December 11, 1960, and the new Joint Committee on General Practice was established and given the assignment to implement this section of the Resolution.

### Committee Preparation and Study

The committee objective was to develop realistic suggestions for each Ohio Dean to consider and discuss with his faculty Curriculum Committee. These suggestions would consider the question: How might each school better expose each undergraduate to the concept of family practice and the doctor of medicine rendering this type of service? Most medical school deans state the mission of their schools usually in simple terms as "to train each student to be a Doctor of Medicine capable of moving into any phase of medical activity he desires." Most deans feel that exposure to types of specialty practice should be done in graduate years only.

One paragraph in the Final Report on Preparation for Family Practice,[1] approved by both the AMA House of Delegates and the Executive Council of the Association of American Medical Colleges, enlarges upon the training a student should have to be a Doctor of Medicine. It comments on the issue as to whether or not there is a place in undergraduate medical education for emphasis on balance between the acquisition of a common fund of knowledge and skills and its application for use in any particular person and his family unit. To quote —

"The educational program in a modern medical school exposes the student to specialty viewpoints. To maintain the objective of providing a sound, balanced medical education, it would seem highly desirable that the student be exposed also to the concept of family practice. Because general care is an important part of

medical practice, medical schools should be encouraged to develop that phase of medical education centered around the patient, his continuing care, his environment, and the use of community resources, to the fullest extent compatible with the total educational program. Educational experiences emphasizing care of ambulatory patients should be an integral part of this program."

The committee preparing this AMA report consisted of 12 physicians, three only of whom were general physicians. It represented a fine balance of medical educators with years of seasoned experience. Three groups were represented — the American Academy of General Practice, the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association. The report is most realistic and prophetic and should be studied by everyone interested in and dedicated to the health needs of the American people.

In addition to studying carefully this AMA report, the OSMA Joint Committee corresponded with many schools offering their undergraduates various types of exposure to family physicians and family practice. Among these were the University of Kansas, University of Tennessee, University of Mississippi, Harvard, Marquette, Vermont, Bowman-Gray, University of North Carolina, University of South Carolina and others.

As a member of the executive committee, Section on General Practice, AMA, I focused attention, nationally, on the problem in a paper[5] appearing in *The Journal of the American Medical Association*. In the article I suggested one of the main reasons for the lack of interest on the part of medical students to enter family practice was their almost total lack of contact with family doctors among their faculty teachers. Many communications, all favorable, came in from all over the world following its release.

### Interim Report to Council

On May 14, 1961, after weeks of careful study and discussion of this background data, the Committee submitted its initial interim report to The Council. The following statements were unanimously agreed upon by the Committee:

"1. It endorses and supports the Final Report on Preparation for Family Practice submitted to the House of Delegates, AMA, by the Committee on Preparation for General Practice, AMA, and approved by them in June 1959. It recommends that this report be endorsed by both Council and the House of Delegates, OSMA, and accepted as the official OSMA position from which this Committee is directed to proceed in its efforts to implement the resolution referred to it by the House of Delegates in its last two meetings.

"2. It recognizes that no two medical schools in Ohio will consider the area of 'Family Practice' and the physician identified as the 'Family Physician' in identical perspectus; however, it urges each medical school in Ohio to include within its undergraduate curriculum certain programs of instruction designed to acquaint and familiarize every student with the concept of 'rendering service over broad areas of medical knowledge to individuals and their families on a continuing basis, regardless of age.'

"3. It is convinced that medical students must be exposed to greater numbers of 'teaching family doctors'— properly prepared, pedagogically, to participate in both undergraduate and graduate teaching — if greater numbers of students are to be guided toward and motivated to accept the challenge of family practice as a way of life.

"4. It believes that an administrative Unit of Family Practice is a necessary and valuable segment of any medical school faculty. Further, that each Ohio Medical School should consider forming such a unit to assist in developing and conducting whatever family practice activities each school considers desirable in its overall program of instruction."

An outline of basic essentials the Committee felt each school would wish to consider as a suggested guide for the establishment and operation of such a unit was attached to the report.

The Committee recommended the following actions by Council:

1. Approval of the report as submitted or altered by Council.

2. That Council authorize the President, Dr. Petznick, to contact each Dean, acquaint him with the activity of the Committee and urge him, or his designated representative, to meet with the Committee to consider the Committee suggestions.

### Council Action

On May 20, 1961, Council met and approved the Committee Interim Report as submitted with commendation for the amount and quality of preliminary work it had accomplished in facing its assignment realistically.

On June 5, 1961, Dr. Petznick, President, OSMA, wrote each Dean, urging him to meet with the Committee in a preliminary conference. Each Dean was sent a copy of the Council approved Interim Report, with its outline of items to consider during the discussion, together with a reprint of the Chairman's paper referred to above.[5]

### Conferences with Each School

Meetings were held with representatives from each school in July, August and September. The OSMA District Councilors for the Cincinnati, Columbus and Cleveland areas were invited and attended each meeting.

Prior to each meeting, the Committee sent each designated representative a syllabus, detailing recommendations for establishing and operating organized "Units of Family Physicians" to participate in undergraduate and graduate instruction within the framework and policy established by each school. Included as part of the syllabus was a three-page outline of the type of instructional material the Committee felt every student, regardless of the area of medical practice he might later decide to enter, should have prior to graduation. This was designed to meet the AMA Committee on Preparation for Family Practice suggestions that to maintain balance in undergraduate medical education every student should be exposed

to the concept of family practice as conducted by family physicians.

The covering letter to each dean emphasized that the committee had no desire to alter the basic educational program or the faculty organization of the school and suggested how its recommendations could be accomplished with a minimum of curriculum changes, faculty changes and financial requirements.

### Blueprint for Action

The Committee will continue its efforts to focus attention on the fact that Ohio needs many more family doctors than its three schools are now supplying. It is the hope of the Committee and the Council of the Ohio State Medical Association that our deans and curriculum committees study carefully and seriously the work of this Committee.

An editorial in the September 8, 1961, issue of the *New England Journal of Medicine* urged medical schools to recognize the area of Family Practice as a true specialty and permit qualified Family Physicians both hospital privileges and teaching assignments within their institutions.

Ohio now has a blueprint for action — our schools need only to alter it to suit each school's pattern of instruction. Lip service concerning the importance of family practice and the family physician in the framework of American medicine has accomplished nothing in the past. It can certainly do nothing in the future.

### References


1. Committee on Preparation for General Practice: Final Report on Preparation for Family Practice. JAMA, **170**:681 (June 6); 1075 (June 27) 1959.
2. Division of Operational Studies of the Association of American Medical Colleges: Survey of American Medical School Senior Students (1959).
3. Zollinger, Robert M.: Presidential Address, Annual Meeting, American College of Surgeons (1961) in publication.
4. OSMA Resolution on Chairs of General Practice (1960 House of Delegates).
5. Rardin, Thomas E.: Medical Students, Family Doctors, and Family Practice. JAMA, 176:479-482 (May 13) 1961.


## Cleveland Clinic Research Unit Moves to Expanded Quarters

Cleveland Clinic's Research Division recently unveiled new quarters for one of the country's largest cardiovascular research programs. Dr. Irvine Page, former president of the American Heart Association and head of the Research Division, announced that the new quarters give a major boost to the Division's various programs.

Heads of teams working on particular projects in the Division include Dr. Merlin Bumpus, Dr. James McCubbin, Dr. Helen Brown, Dr. Willem Kolff and Researcher Frederick Olmstead. In addition to physicians conducting clinical studies, the program includes researchers in chemistry, biochemistry, neurology, electronics, diet and other areas.

Much of the work of the division is supported by grants from the Cleveland Area Heart Society, American Heart Association, the National Institutes of Health and other groups.

## Radiation Registration Forms To Be Mailed Soon

HERE'S the answer to physicians who use a radiation device or radioactive material in their practice and have asked how to register under the new Radiation Registration Law, effective January 1 and which was referred to in the November 27 OSMAgram and the December issue of *The Ohio State Medical Journal*:

Sit tight and wait until you get material from the Ohio Department of Health by direct mail.

Registration forms and explanatory material are being prepared by the health department. They will be mailed to physicians as soon as the printing is completed. Until then, physicians are not obligated to do anything toward complying with the new law.

## Woman's Auxiliary Lauded By House of Representatives

The following resolution, introduced by State Rep. Walter E. Powell, Butler County, commending the Woman's Auxiliary of the Ohio State Medical Association, was adopted unanimously by the Ohio House of Representatives on November 16:

"WHEREAS, The members of the House of Representatives of the 104th General Assembly of Ohio note with deep appreciation the accomplishments of the Woman's Auxiliary of the Ohio State Medical Association and their contribution to our great state in the fields of health and safety; and

"WHEREAS, Numbered among their many accomplishments and contributions is their sponsorship of health careers clubs in high schools throughout the state providing students the opportunity to familiarize themselves with the fields of health and medicine; and

"WHEREAS, They provide each year scholarships to worthy Ohio students for study in health careers, medical technology and allied fields; and have provided over $25,000 in 1961 to medical schools through the American Medical Education Foundation; and

"WHEREAS, They have made major contributions in the fields of school safety and water safety as well as in the health careers field and were recognized for their work in 1960 by the Ohio Civilian Defense Corps; and

"WHEREAS, In addition to their many and varied activities they are this year sponsoring the first annual Ohio Health Careers Week, during the week of November 13th, 1961, to spotlight the opportunities for young people in health careers, medical technology, and allied fields; therefore be it

"*Resolved,* That we the members of the House of Representatives of the 104th General Assembly of Ohio adopt this resolution and cause a copy thereof to be spread upon the journal as a tribute to the endeavors and the accomplishments of the Woman's Auxiliary of the Ohio State Medical Association, to each of its local units, and to each individual member who has given so unstintingly of her time, and that we hereby recognize the week of November 13th, 1961, as Ohio Health Careers Week and commend the Woman's Auxiliary of the Ohio State Medical Association for their initiative in this endeavor; and be it further

"*Resolved,* That the clerk of the House of Representatives transmit duly authenticated copies of this resolution to Mrs. Lester Sontag, President of the Woman's Auxiliary of the Ohio State Medical Association."

# Laboratory Survey . . .

## Ohio Pathologists Use Five Services To Maintain High Standards: List of Those Who Participate

RESULTS of a survey by the OSMA's Committee on Laboratory Medicine in conjunction with the Ohio Society of Pathologists show 89 pathologists in Ohio reporting that they participate regularly in two or more evaluation programs to help them maintain high laboratory standards.

Of the 158 pathologists mailed survey questionnaires, 89 answered and returned the forms, with 84 of the 89 agreeing to having published their names and the check programs in which they participate regularly.

In another program aimed at maintaining high laboratory standards, the Committee sponsors postgraduate workshops for laboratory technicians, these workshops being held three to four times a year in Columbus, Youngstown, Cleveland, Cincinnati, Dayton and Toledo. Medical technologists are invited to participate in the workshops held in their respective regions of the state, and without charge.

The evaluation and proficiency programs included in the questionnaire are as follows:

American Society of Clinical Pathologists Check Sample Program: Monthly unknowns in various phases of clinical pathology, such as hematology, immunohematology, chemistry, bacteriology, serology, toxiciology, and others, are submitted to participants who perform the examinations and report the results. A short time later, the participants receive a listing of the correct results and a critique of methods used.

Ohio Department of Health Serology and Bacteriology-Parisitology Surveys: Unknown samples of bacteria immune sera, parasites or similar material are submitted to participating laboratories. Results are returned to the Department of Health, tabulated and a summary of results and correct findings are made available to participants.

F. W. Sunderman Proficiency Test Service: This Philadelphia pathologist founded and directs a private proficiency survey in which monthly mailings of chemical samples of stated composition but known concentration are mailed to physician subscribers. Results are submitted anonymously and correct results plus extensive discussion of methods are returned to the participants.

College of American Pathologists Proficiency Survey: Periodic unknown samples of a chemical or bacterial nature are submitted for analysis by the participants. Results are returned to the CAP and correct findings are then submitted to participants.

American Association of Blood Banks: This is a program of inspection and accreditation of hospital blood banks to insure adequacy of personnel, facilities, policy and procedures.

The pathologists who agreed to publication of the information reported their participation as follows:

| Pathologist | * | A | B-1 | B-2 | C | D | E |
|---|---|---|---|---|---|---|---|
| ("X" indicates laboratory reported it participates in evaluation programs) | | | | | | | |
| Margaret Baker, M. D. Children's Hospital, Akron | | x | x | x | x | | |
| George R. Dochat, M. D. Akron General Hospital, Akron | | x | x | x | x | | x |
| George G. Proskauer, M. D. St. Thomas Hospital, Akron | | | x | x | | | |
| J. Jason Dixon, M. D. Ashtabula General Hosp., Ashtabula | | | x | | x | | |
| Frank T. Hamilton, M. D. Citizens Hospital, Barberton | | x | x | | x | | |
| Hammond Chen, M. D. Aultman Hospital, Canton | | x | x | x | x | | x |
| Frank B. Queen, M. D. Aultman Hospital, Canton | | x | x | x | x | | x |
| Fabio Rodriguez, M. D. Canton | | x | x | | | | |
| Frank P. Cleveland, M. D.<br>R. J. Ritterhoff, M. D.<br>Klaus Stemmer, M. D. | Cincinnati | x | x | | | | |
| Edward A. Goll, M. D. General Hospital, Cincinnati | | x | x | x | x | | x |
| Louis Z. Gordon, M. D. Good Samaritan Hospital, Cincinnati | | x | x | x | | | |
| John B. Hamblett, M. D. Bethesda Hospital, Cincinnati | | | x | x | x | | |
| Paul N. Jolly, M. D. The Christ Hospital, Cincinnati | | x | x | | | x | x |
| Philip Wasserman, M. D. Jewish Hospital, Cincinnati | | x | x | x | x | x | |
| Bruce F. Andreas, M. D. The Woman's Hospital, Cleveland | | x | x | x | x | | |
| Paul D. DeWitt, M. D. Miles Medical Laboratory, Cleveland | | x | x | | x | | |
| Harold Gold, M. D. Mt. Sinai Hospital, Cleveland | | x | x | x | x | | x |
| Edward Goodsitt, M. D. Huron Road Hospital, Cleveland | | x | x | x | | x | x |
| Lawrence McCormack, M. D.<br>William A. Hawk, M. D.<br>John W. King, M. D. | Cleveland | x | x | | x | | |
| J. D. Kernodle, M. D. Doctors Hospital, Cleveland | | x | x | | x | | x |
| E. Frederick Koster, M. D. St. John's Hospital, Cleveland | | x | x | x | x | | x |
| John S. Mackrell, Jr., M. D. St. Vincent Charity Hosp., Cleveland | | x | x | x | x | x | |
| Hugh F. McCorkle, M. D. Fairview Park Hospital, Cleveland | | | x | x | x | | |
| Oscar A. Ross, M. D. Euclid-Glenville Hosp., Cleveland | | | x | | x | | x |
| A. J. Segal, M. D. St. Luke's Hospital, Cleveland | | | x | x | x | | |
| Edward E. Siegler, M. D. Marymount Hospital, Cleveland | | x | x | x | | x | x |
| J. Chandler Smith, M. D. University Hospitals, Cleveland | | x | x | | | | x |
| Horace B. Davidson, M. D. Columbus | | x | x | x | x | x | |
| Ralph J. Johansmann, M. D. Riverside Methodist Hosp., Columbus | | | x | x | x | | |
| C. R. Mac Pherson, M. D. Ohio State University Hosp., Cols. | | | x | x | | | x |
| Edward M. Miller, M. D. Columbus | | | x | | | | |
| Wm. Newton, Jr., M. D. Children's Hospital, Columbus | | | x | x | | x | |

| Pathologist | * | A | B-1 | B-2 | C | D | E |
|---|---|---|---|---|---|---|---|
| Horace B. Davidson, M. D. Mt. Carmel Hospital, Columbus | | x | x | x | x | x | x |
| L. H. Von Der Hoeven, M. D. Columbus | | x | | | x | | |
| Emmerich von Haam, M. D. (Cols.) Chillicothe Hospital, Chillicothe | | | x | x | | | |
| William Abramson, M. D. St. Elizabeth Hospital, Dayton | | | x | | x | | |
| Charles A. Dille, M. D. Dayton | | | x | x | | | |
| James B. McMillan, M. D. Good Samaritan Hospital, Dayton | | x | x | x | x | | x |
| Melvin Oosting, M. D. Miami Valley Hospital, Dayton | | x | x | x | x | | |
| Charles C. Thomas, M. D. Veterans Administration Center, Dayton | | | x | x | | | |
| Roy C. Costello, M. D. City Hospital, East Liverpool | | | x | x | | | x |
| R. G. Thomas, M. D. Memorial Hospital, Elyria | | x | x | x | x | | |
| Manuel Sarmina, M. D. Findlay | | x | x | | x | x | |
| John Zimmerman, M. D. Memorial Hosp. of Sandusky Co., Fremont | | x | x | x | | x | |
| Johnson H. Chow, M. D. Community Hospital, Galion | | | x | x | x | | x |
| Dane Barber, M. D. Fort Hamilton Hosp., Hamilton | | | x | x | x | x | |
| Kurt E. Lande, M. D. Mercy Hospital, Hamilton | | x | x | x | x | | |
| Paul D. Miller, M. D. Lancaster-Fairfield Hosp., Lancaster | | | x | | x | x | |
| C. L. Blumstein, M. D. St. Rita's Hospital, Lima | | x | x | | x | x | x |
| Donald E. Hughes, M. D. St. Rita's Hospital, Lima | | x | x | | x | x | |
| William T. Collins, M. D. Memorial Hospital, Lima | | | x | x | x | | |
| Gertrude E. Warner, M. D. Lodi Community Hospital, Lodi | | x | x | x | | | |
| Charles Chesner, M. D. Lorain | | x | x | x | x | | |
| Robert C. Harsh, M. D. General Hospital, Mansfield | | x | x | x | x | | |
| David B. Thornburgh, M. D. Guernsey Memorial Hosp., Cambridge & Marietta Memorial Hosp., Marietta | | x | x | x | | | |
| Ann H. Oyer, M. D. Middletown Hosp. Assn., Middletown | | x | x | | | | x |
| James A. Quinn, Jr., M. D. Newark Hospital Association, Newark | | x | x | x | x | | x |
| J. T. Gohmann, M. D. Mercy Hospital, Portsmouth | | x | x | x | x | | |
| Robert E. Glasgow, M. D. Robinson Memorial Hosp., Ravenna | | | x | x | x | | |
| William A. Kolozsi, M. D. City Hospital, Salem | | x | x | x | x | | |
| Mary P. Hunter, M. D. Mercy Hospital, Springfield | | x | x | | x | | |
| Robert E. Wybel, M. D. City Hospital, Springfield | | x | x | x | x | | |
| Harry W. Haverland, M. D. Ohio Valley Hospital, Steubenville | | | x | x | x | | |
| Albert O. Halloran, M. D. Mercy Hospital, Tiffin | | | x | | | x | |
| D. J. Hanson, M. D. & E. L. Burns, M. D., Mercy Hospital, Toledo | | x | x | x | x | x | x |
| W. H. Hartung, M. D. St. Charles Hospital, Toledo | | x | x | x | x | x | x |
| A. E. Rhoden, M. D. St. Luke's Hospital, Toledo | | x | x | | x | | x |
| James B. Rucker, M. D. Mercy Hospital, Toledo | | | x | x | | | x |
| John Snavely, M. D. Maumee Valley Hospital, Toledo | | x | x | x | x | | |
| Bernhard Steinberg, M. D. The Toledo Hosp. Laboratories, Toledo | | | x | x | | | x |
| M. F. Vidoli, M. D. St. Vincent's Hospital, Toledo | | x | x | x | x | | |
| Donald C. Wilson, M. D. Riverside Hospital, Toledo | | x | x | x | x | | |
| Carl G. Hoak, M. D. Dettmer General Hospital, Troy | | x | x | x | x | | |
| Gertrude E. Warner, M. D. Municipal Hospital, Wadsworth | | x | x | x | x | x | |
| Arthur M. Ginzler, M. D. St. Joseph Riverside Hosp., Warren | | x | x | x | x | x | |
| Robert J. Williams, M. D. Trumbull Memorial Hosp., Warren | | | x | | x | | |
| Robert Schultz, M. D. Community Hospital, Wooster | | x | x | x | x | | |
| A. E. Rappoport, M. D. Youngstown Hos. Assn., Youngstown | | x | x | x | x | | x |
| Wm. B. Smith, M. D. Good Samaritan Hosp., Zanesville | | | x | x | | x | |

*KEY: A — American Society of Clinical Pathologists (check sample program).

*KEY: B — Ohio Department of Health (1) Serology and (2) Bacteriology and Parasitology.

C — College of American Pathologists Technical Proficiency Survey.

D — F. W. Sunderman, M. D., Proficiency Testing Service, Philadelphia.

E — American Association of Blood Banks Certification (X means accredited).

## Selective Service Ruling on Interns and Residents

The following paragraphs are quoted from Operations Bulletin No. 177 of Selective Service, as amended November 3, 1961, paragraphs refer to the liability of interns and residents for military service:

"**Classification of Interns and Residents.** (a) Local boards should continue to give serious consideration to the deferment in Class II-A of a registrant who is a physician, in order that he may complete internship.

"(b) A physician should not be placed in Class II-A for the purpose of completing a residency unless (1) in the opinion of the local board his services are essential to the operation of the hospital, or (2) he is one who has been certified for essential training by the Public Health Service on Request for Deferment and Hospital Agreement (PHS Form 2525).

"4. **Public Health Service Residency Program.** (a) To insure that the Public Health Service will continue to receive reserve medical officers who have had residency training in specialized fields, the Director of Selective Service and the Public Health Service have agreed to continue the Public Health Service Commissioned Officer Residency Consideration Program.

"(b) This program permits a limited number of registrants who are or become commissioned medical reserve officers to complete residency training prior to being called to active duty. To implement this agreement, the Director of Selective Service recommends the deferment of registrants who may be selected by the Public Health Service for essential residency training under this program.

"(c) Each selected registrant will be certified to the Selective Service System on Request for Deferment and Hospital Agreement (PHS 2525). The Director of Selective Service will forward this form to the registrant's local board through the appropriate State Director of Selective Service.

"5. **Armed Forces Residency Program.** The Armed Forces will continue to permit some reserve officers commissioned as physicians to complete residency training prior to entering on active duty. The Record of Military Status of Registrant (DD Form 44) submitted to the local board by such a registrant's armed force certifying that he is serving satisfactorily as a member of the Ready Reserve shall qualify him for consideration for classification in Class I-D under the provisions of section 1622.13(1) of the regulations."

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The Gill Memorial Eye, Ear and Throat Hospital, 711 So. Jefferson St., Roanoke, Va., has announced its 35th annual spring congress in ophthalmology and otolaryngology for April 2-6, 1962. Among speakers will be Dr. R. L. Hilsinger, Cincinnati. Details may be obtained by writing the Superintendent, P. O. Box 1789, Roanoke, Va.

# Annual Conference of County Medical Society Officials To Be Held in Columbus on Sunday, February 25

PLANS are being completed for the program to be presented at the Annual Conference of County Society Officers and Committee Chairmen on Sunday, February 25, at the Deshler Hilton Hotel, Columbus.

Special invitations will be mailed as rapidly as the County Medical Societies report their officers and committee chairmen to the Columbus Office.

This conference sponsored by the Ohio State Medical Association is one of the highlights of medical activities in Ohio each year.

The theme of the morning program will be "Medicine's Battle of the Century" and will cover political and legislative activities, especially H. R. 4222, the compulsory health insurance bill for Social Security beneficiaries.

Among the participants will be Dr. Ernest B. Howard, assistant executive vice-president of the American Medical Association, and Mr. Joe D. Miller, executive director of the American Medical Political Action Committee.

"Medicine in Action" will be the theme of the afternoon program which will cover state and local activities in a half dozen important fields.

## Columbus Area Society Offers Awards for Manuscripts

The Columbus Society of Internal Medicine, to encourage clinical and research investigation at the graduate level, is offering on an annual basis, awards for the three best manuscripts submitted. These awards are in the amount of $250, $150 and $100 respectively. Selected manuscripts will be read by the authors at the spring meeting of the Society in June 1962.

All interns, resident physicians and those who are within a three year training program beyond their intern status, in the specialty of Internal Medicine and any of the allied sub-specialties, are invited to submit a manuscript on or before April 1, 1962.

Investigation of either a clinical or research nature will be acceptable, providing the work was performed in a local institution within the central Ohio area served by the Columbus Society.

Members of the Awards Committee are: Dr. Jack S. Silberstein, Chairman, 350 E. Broad St., Columbus 15; Drs. Michael Anthony, George Morrice, James Schieve and Donald Vincent. Those interested are invited to contact a member of the committee for particulars.

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The New Orleans Graduate Medical Assembly has announced its 25th annual meeting to be held at the Roosevelt Hotel, March 12-15. Also the 18th annual clinical tour has been arranged immediately following the program. Persons interested should contact Minnie D. Paine, M. D., Secretary, at 1430 Tulane Ave., New Orleans 12, Louisiana.

## Recent Opinions of the Attorney General

Following is the syllabus of an opinion given recently by Attorney General Mark McElroy:

Under Secs. 339.01 to 339.14, inclusive, R. C., a board of trustees of a county hospital is without authority to contract with a private consulting firm for the furnishing of a survey on the needs and future development of the hospital. Opinion No. 2397.

* * *

Revenues derived from a levy authorized by Section 5705.20, Revised Code, for the support of a tuberculosis hospital are not prohibited by the provisions of Section 339.45, Revised Code, from being used for the care, treatment and maintenance of patients admitted to such hospital with illnesses other than tuberculosis. — Opinion No. 2312.

* * *

Attorney General Mark McElroy in a recent opinion said bona fide students of dentistry may give services in a private home, if the services are part of their dental college course.

Under the law, dental services may be performed only by licensed dentists, except that bona fide students of dentistry may give dental services in the clinic rooms of a reputable dental college.

"I conclude, therefore," the opinion stated "that the words 'clinic rooms,' as used in Ohio law, include places where dental students receive instruction and practical experience in dentistry, under dental school faculty supervision, even though such places are not located at the dental college."

# Facts and Policies About Annual Dues...

## Amount of Dues; Payable by Whom; Exemptions; AMA Dues and Exemptions; Getting Journals

HERE are some important facts and reminders regarding 1962 membership dues. It is vital for each physician to keep his membership in the State Association, his county Medical Society, and the AMA up to date. Those who have not paid 1962 dues should get in touch with their County Society secretary-treasurer immediately.

Amount of Dues: State Association, $30.00 or $7.50 in the case of interns and residents; AMA, $35.00; County Society, amount varies from county to county — See your local secretary-treasurer.

**Membership and Dues for Residents and Interns:** A physician serving a hospital internship or residency approved by the AMA Council on Medical Education and Hospitals, who becomes a member of a county medical society and meets the membership eligibility requirements of the OSMA Bylaws does not have to pay full state dues for 1962. By official action of The Council September 15-17, 1961, state dues for such members were set for 1962 at $7.50. Such members will receive *The Journal* automatically.

So far as AMA membership is concerned, the AMA Bylaws provide that it may excuse from the payment of AMA dues, interns and residents provided their local and state dues are fully or partially waived. Therefore, intern and resident members in Ohio who are assessed the partial dues ($7.50) will be entitled to AMA membership without payment of AMA dues. However, in order to receive the AMA *Journal* or some other AMA publication, they will have to purchase a regular subscription from the AMA at one-half the regular price.

**Date Dues are Due:** On or before January 1, 1962. Membership is on a calendar year basis.

**Dues Payable to Whom?** Secretary-treasurer of County Medical Society. When paying dues to him, send check for total amount of local, State and AMA dues. Maintaining membership in the AMA is optional, but the large majority of Ohio physicians belong to the AMA. Don't send dues direct to Columbus Office — pay them to local secretary-treasurer.

**Who is Exempt From State Dues?** There are only two classes of members of the OSMA who are exempt from the payment of state dues, namely:

(a) **Military Members:** Members of the OSMA on extended active duty in the military service or U. S. Public Health Service but who are not making military medicine or public health work a career, are entitled to **exemption from OSMA membership dues** while they are in the service. Dues paid by a member before entering the service will not be refunded, but dues will be waived if he enters the service prior to paying dues. Certification from local secretaries will be necessary in all such cases.

(b) **Aged or Disabled Members:** A member who **retires,** or has been retired, from active practice because of **age or disability** and who was in good standing at the time of retirement is exempt from the payment of State dues, **providing he requests such exemption and such request is approved in writing by the secretary-treasurer of his county medical society.**

**Remember: The determining factor is not how old the physician is but whether he has retired from active practice.**

**Who Is Exempt From AMA Dues?** The following physicians, who are members of the OSMA either through payment of OSMA dues or by exemption of OSMA dues, can carry membership in the AMA without paying AMA dues:

(a) **Military Members:** OSMA members in temporary military service prior to January 1, 1962, are entitled to AMA membership **without payment of dues.** Members entering military service prior to July 1, 1962, will owe AMA membership dues of $17.50 — one-half year; those entering military service after July 1, 1962, will owe dues for the entire year — $35.00. Military members for whom AMA dues are waived and who desire to receive *The AMA Journal* while in the service may do so by buying, directly from the AMA, an annual subscription of one-half the regular price, or $7.50. The *OSMA Journal* is sent to such members without charge.

(b) **Aged and Disabled Members:** OSMA members who are exempt from payment of OSMA dues because of retirement from active practice due to **age or disability** are entitled to AMA membership without payment of AMA dues. The names of such members will be certified automatically to the AMA annually by the Columbus Office after their names are entered on the OSMA roster as dues-exempt members for the current year.

(c) **Members 70 years of age:** Members of the

OSMA, after attaining the age of 70 years, will be eligible for membership in the AMA without paying AMA dues, starting on January 1 following such member's 70th birthday, providing such member requests such exemption. Such members should file their request for AMA exemption with the Columbus Office after they have received their OSMA membership card for 1962, or any subsequent current year. The Columbus Office will certify their names to the AMA. This AMA exemption will be automatic year by year, providing the physician's name is carried on the membership roster of the OSMA, either as a dues-paying member or as a retired member. To get the *AMA Journal* these 70-year old members must purchase a subscription at one-half the regular price, or $7.50.

(d) Members of the OSMA who are serving an internship or residency. This is because their dues are partially waived by the OSMA (they pay only $7.50 to OSMA).

**Those not exempt from OSMA dues:** The following are not exempt from the payment of OSMA dues, either $30.00 or $7.50:

(a) **Members in practice or in internship or residency training.** As mentioned previously, those in internship or residency are assessed dues of $7.50 — not $30.00 the dues of other classes of paying members.

(b) **Regular commissioned medical officers of the Army, Navy, Air Force, or U. S. Public Health Service, and permanent medical officers of the Veterans Service and the Indian Service are NOT exempt from OSMA dues.** If they desire to be members of the OSMA, they must qualify the same as civilian physicians and pay current dues. However, physicians of these classes are eligible to apply for **Service Membership in the AMA**, and if accepted into Service Membership, will not be required to pay AMA dues.

**Send Change of Address Promptly:** Occasionally a new member wonders why he does not receive the OSMA and AMA journals at once. The answer is simple. It takes the OSMA Columbus Office about four weeks to get a new stencil made and the mailing list adjusted to take care of mailings to new members. It takes the AMA longer because of its very large mailing list. Also, some months extra copies of the journals are quickly exhausted. Moreover, the Post Office Department frequently causes the delay in delivery especially if the office does not have the member's street number, office room number and zone number. The Columbus Office makes a real effort to send out OSMA journals to new members by special handling but that can't always be expedited. If a new member fails to get the magazine on two consecutive months, something is wrong and he should notify the Columbus Office. All members can help the Columbus Office in keeping the mailing list up to date by sending in changes of address promptly.

*The Ohio State Medical Journal*: Members, who pay full dues or are exempt from payment of any dues, receive *The Ohio State Medical Journal* as a part of their membership privileges — no extra charge for *OSMA Journal*.

Active dues-paying members of the AMA receive *The Journal of the AMA;* the *AMA News; Today's Health* and one AMA Specialty Journal of their choice as a member benefit. These Specialty Journals are: *Archives of Internal Medicine, American Journal of Diseases of Children, Archives of Dermatology, Archives of Neurology, Archives of General Psychiatry, Archives of Pathology, Archives of Surgery, Archives of Otolaryngology, Archives of Ophthalmology. Archives of Environmental Health.*

Non-dues-paying members must subscribe directly to the Chicago Office for any AMA publication, at one-half the regular price.

## Physicians Exempted By Dangerous Drug Act

Some physicians have inquired whether they have to obtain a license as a terminal distributor under the newly-enacted Ohio Dangerous Drug Act.

The answer is "No." Practitioners, defined by the law as licensed physicians, dentists, veterinarians or other medical practitioners licensed to write prescriptions, are specifically exempted by the law.

A terminal distributor, who has to be licensed, is defined by the law as a person, other than a practitioner, wholesale distributor or pharmacist, who is engaged in the sale of dangerous drugs at retail or who has in his possession, custody or control dangerous drugs for any purpose other than for his own use or consumption. Licensure would include a pharmacy, nursing home, industrial first-aid room, laboratories, or any outlet which purchases, stores or dispenses or uses a dangerous drug under the supervision of a pharmacist or practitioner.

## Blood Bank Directory To Be Published

Over 4,500 hospitals, Red Cross, and community blood banks are now being surveyed to determine and record their identities and relationship to transfusion services and blood banking. Specific data is being gathered to determine the number of units of human blood collected and transfused by each institution. This and other information will be published early in 1962 in a third edition of "Directory of Blood Transfusion Facilities and Services" by the Joint Blood Council.





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1. Sollmann, T.: A Manual of Pharmacology and Its Applications to Therapeutics and Toxicology, ed. 8, Philadelphia, W. B. Saunders Company, 1957, p. 206.

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# Protecting High School Athletes . . .

## Survey Reveals Interesting Data on Medical Care And Insurance To Protect the Student in Sports

THE Joint Advisory Committee on Athletic Injuries of the Ohio State Medical Association and the Ohio High School Athletic Association has sponsored a survey of current practices with regard to medical care and insurance coverage of Ohio High School athletes.

The survey was conduced by the Ohio High School Athletic Association under the direction of Mr. Nick Mourouzis, a graduate student at the Ohio University, who wrote the accompanying survey findings. Mr. Mourouzis used the survey as the basis of work submitted for an advanced degree.

County medical society school health chairmen, officers, and members of medical societies will find in the summary below a good "check sheet" on the status of the work of the physicians and the schools in their locality. Physicians and educators should work together to provide the best protection possible for high school athletes. Medical societies should take the leadership in offering to assist the school systems in developing policies and programs.

### Introduction to Survey

The Committee on the Medical Aspects of Sports of the American Medical Association and the Joint Advisory Committee on Athletic Injuries in the State of Ohio have taken great strides in the prevention and control of athletic injuries.

Both of these committees advocate the "Sports Injury Conferences" as a means of safeguarding the health and safety of high school sports participants. The latter group, which is composed of representatives from the Ohio State Medical Association and the Ohio High School Athletic Association, jointly sponsored "Athletic Injury Conferences" throughout the State of Ohio during 1959 and 1960. In 1960 this Joint Advisory Committee initiated the "Post-Graduate Institute for Physicians on Medical Aspects of High School Athletics."

### Survey of Current Practices

The activities sponsored by the Joint Advisory Committee have provided a means of in-service education in the prevention and treatment of athletic injuries for coaches, athletic directors, faculty managers, school administrators, physical education and health education teachers, physicians, and all others interested. This committee conducted a survey of current practices pertaining to the medical care and insurance coverage of high school athletics.

The results of the survey indicated that the majority of the schools have a physician who is ultimately responsible for advice, referral, and treatment of athletic injuries.

### Medical Emergencies

The survey revealed that less than one-third (30 per cent) of the schools that responded to the questionnaire had written policies governing procedures to be followed when a medical emergency occurs during practice sessions. This indicates that schools have been negligent in establishing written policies or procedures to follow when a medical emergency arises during practice sessions.

The results of the survey revealed that the premiums for athletic-injury insurance were purchased by (1) the parents, or jointly by (2) the school and parents. Some of the schools (19 per cent) purchased the insurance for the athletes.

One distinct weakness was evident in that some insurance companies do not offer coverage for negative x-rays (x-ray pictures that show no fractures) or have only partial coverage for negative x-rays. Insurance is bought primarily for protection; therefore, it is necessary for athletic-injury insurance to cover negative x-rays as well as positive x-rays, since the recognition of negative x-rays leads to proper control, referral, and treatment of injuries that occur.

The survey revealed that there were thirty insurance companies offering athletic injury coverage in the State of Ohio.

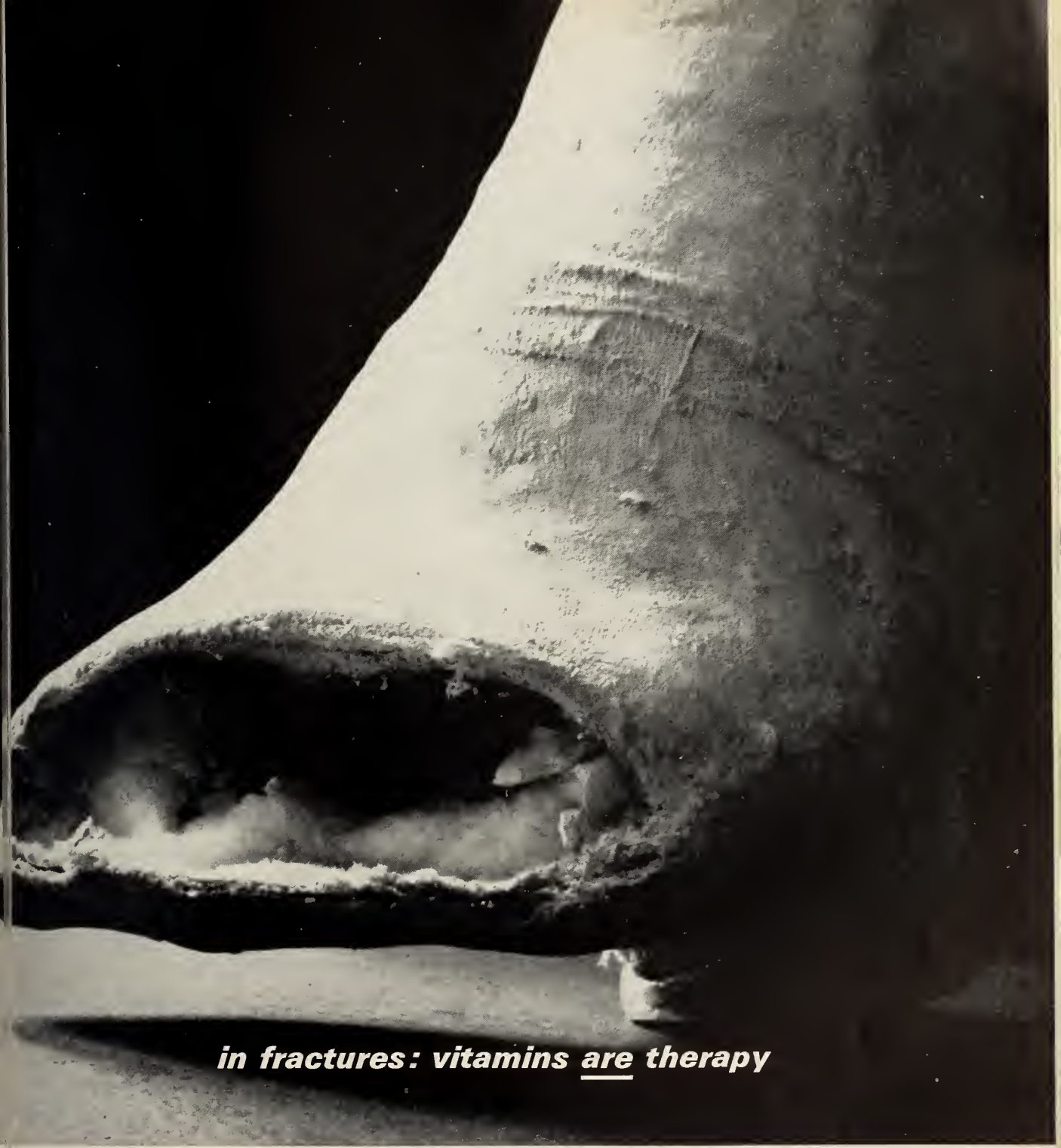
### Insurance Patterns Revealed

Eight per cent of the schools that responded to the questionnaire did not have an insurance plan for the protection of pupils participating in athletics. These schools, however, followed one of the general patterns listed below:

Individual schools accumulated their own reserve fund to cover athletic injuries.

Groups of schools pooled their resources through county previews or league games.

Individual schools allotted between 5 and 10 per



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cent of their yearly budgets for the accumulation of a medical fund.

Individual schools placed the responsibility for the payment of athletic injuries on the parents.

### Analysis of Plans Offered

The analysis and comparison of the five leading insurance companies offering medical coverage to high school athletes in the State of Ohio revealed the following factors:

Four of the five insurance companies offered blanket type coverage. Only one company offered a schedule of benefits coverage.

Only two companies offered athletic injury insurance coverage without requiring the schools to adopt the student accident plan for all students.

Most regular student accident insurance plans covered all sports except football.

The cost for insuring football players ranged from six dollars to nineteen dollars and twenty-five cents.

Dental coverage ranged from twenty-five dollars per tooth to an aggregate amount of one hundred and fifty dollars.

The maximum medical expenses ranged from five hundred dollars to five thousand dollars.

### Medical Care Findings

The following conclusions were evident in the survey on current practices pertaining to medical care and insurance coverage of high school athletes in Ohio:

All schools except one presented at least once each year a physician's certificate stating that a pupil is physically fit for athletic competition.

More than four-fifths (83 per cent) of the schools gave their physical examination "in private and quiet."

Less than one-fifth of the schools provided a physical examination for players who reported for a second sport. A more distinct drop was evident when only 7 per cent of the schools gave physical examinations to players reporting for a third sport.

The three most widely used methods of performing the physical examinations were as follows: family physician, team physician, and school physician.

The majority of schools sponsoring football had a physician present during a game.

Many of the schools did not have a physician present at basketball games, baseball games, and wrestling meets. This may be attributed to the fact that injuries are less likely to occur in these sports.

The two most widely used arrangements for a physician's attendance at games were a regular team physician and a physician supplied by the home team. Less than one-fifth (17 per cent) of the schools made no arrangements for a physician's attendance at games.

### Want Physician Assigned

The majority of those schools participating in football were in favor of a physician assigned through the County Medical Society.

The majority of schools having football indicated they have a physician available for emergencies during football practice sessions.

Nearly seven-tenths (69 per cent) of the schools had a member of the school staff qualified by training or experience to act as "trainer" for practice sessions and games.

Most of the schools had regular access to medical advice from a physician as to conditioning, fitness and referral, and treatment of injuries. It may be implied that physicians were more than willing to offer suggestions and advice to the coaches in reference to athletic injuries.

In nine out of ten schools a physician gave permission before an injured athlete returned to participation.

### Rely on Physician's Decision

The majority of schools relied on the physician's decision as to whether or not an athlete re-entered or continued play following an injury during contests.

Seven out of ten schools did not have written policies to follow when medical emergencies arose in practice sessions or games.

More than nine-tenths (92 per cent) of the schools in the State of Ohio had an insurance plan for the protection of pupils participating in athletics.

Most of the schools indicated that the insurance coverage for athletes was purchased by either the "parents" or by the "school and parents" and nearly one-fifth of the schools were taking sole responsibility in the purchasing of athletic insurance.

More than four-fifths of the schools had insurance coverage for the three basic areas of hospitalization, x-rays, and medical fees, although these schools did not uniformly have all three types of the basic coverage.

Most of the schools had insurance coverage for both positive and negative x-rays.

Thirty insurance companies offered athletic injury insurance coverage for athletes in the State of Ohio.

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## New AMA Guides on Permanent Impairment Available

Reprints of the fourth in a series of articles entitled "Guides to the Evaluation of Permanent Impairment" are now available from the American Medical Association's Committee on Medical Rating of Physical Impairment, 535 N. Dearborn Street, Chicago 10.

The new booklet is entitled, "Guides to the Evaluation of Permanent Impairment—Ear, Nose, Throat and Related Structures."

The other guides, reprints of which are available also from the AMA, in the series are:

"A Guide to the Evaluation of Permanent Impairment of the Extremities and Back"

"Guides to the Evaluation of Permanent Impairment—The Visual System"

"Guides to the Evaluation of Permanent Impairment—The Cardiovascular System."



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**Bibliography: 1.** Cohen, A., et al.: J.A.M.A. 165:225, 1957. **2.** Spies, T. D., et al.: J.A.M.A. 159:645, 1955. **3.** Moravec, C. L. and Moravec, M. E.: Clin. Med. 7:2322, 1960. H-416

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Out of the Blue

# Full, Accurate Data Needed To Settle Claims

By R. DEAN DOOLEY, M. D.
Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

COMMUNICATION is still one of the most important activities of Ohio Medical Indemnity. Of course, our primary mission is to pay claims so that our subscribers will have better means of paying physicians' bills, yet, we cannot pay claims unless we have information to make the proper judgment. Out of 39,451 claims submitted in the month of October, correspondence with physicians was necessary in 957 or 2.42 per cent of the total. This determination was made in a study in which all claims bearing correspondence either to or from physicians were removed from the file, studied and analyzed.

We found it necessary to correspond with physicians to request additional technical data in 569 instances or 59.46 per cent. The response to our letters supplied information which resulted in an increased indemnity to 171 subscribers or 30.05 per cent. The next category requiring physicians' correspondence was due to statistical errors. It was necessary to write 143 letters or 14.94 per cent of the total to seek information on statistical matters. This correspondence resulted in an increased payment to the subscribers in 4.2 per cent of the cases.

### Other Types of Letters

Other letters were sent to request general information and some of the correspondence originated from dissatisfaction with benefits and many came as a result of misunderstanding.

In reviewing the claims, I found many were illegible and the information fragmentary. I was impressed that our Claim Department does amazingly well in deciphering and fitting together the informational fragments to allow a proper judgment of the claim.

While approximately 45 letters are dispatched to physicians daily, this correspondence is only a minor part of the total. The great bulk of our correspondence is exchanged with our subscribers on a great variety of subjects.

### About Assignments

The assignment feature has been changed in our new claim to a more advantageous position and we have deleted the "X" which seems to automatically invite a signature. It is extremely important to treat the assignment as a legal and binding transaction and the same caution should be exercised in its execution as in other legal documents. The subscriber must authorize the assignment and no other person without the power of attorney can properly act for him.

Much misunderstanding and criticism will be avoided if the patient is informed of the assignment and what his signature denotes. Patients sometimes take this matter too lightly and are surprised and hurt when they receive a check drawn with a second payee.

### Explain to Patient

In many physicians' offices, assignments are routine and I am sure in most instances patients are properly advised at the time the claim is completed. If this is routinely done, there will be little chance that the receipt of a check by the subscriber bearing the name of his physician will place any strain on the patient-physician relationship.

Correspondence is a component part of an insurance operation and remember, it is as unpleasant for us to disturb you with a routine letter as it is for you to receive one.

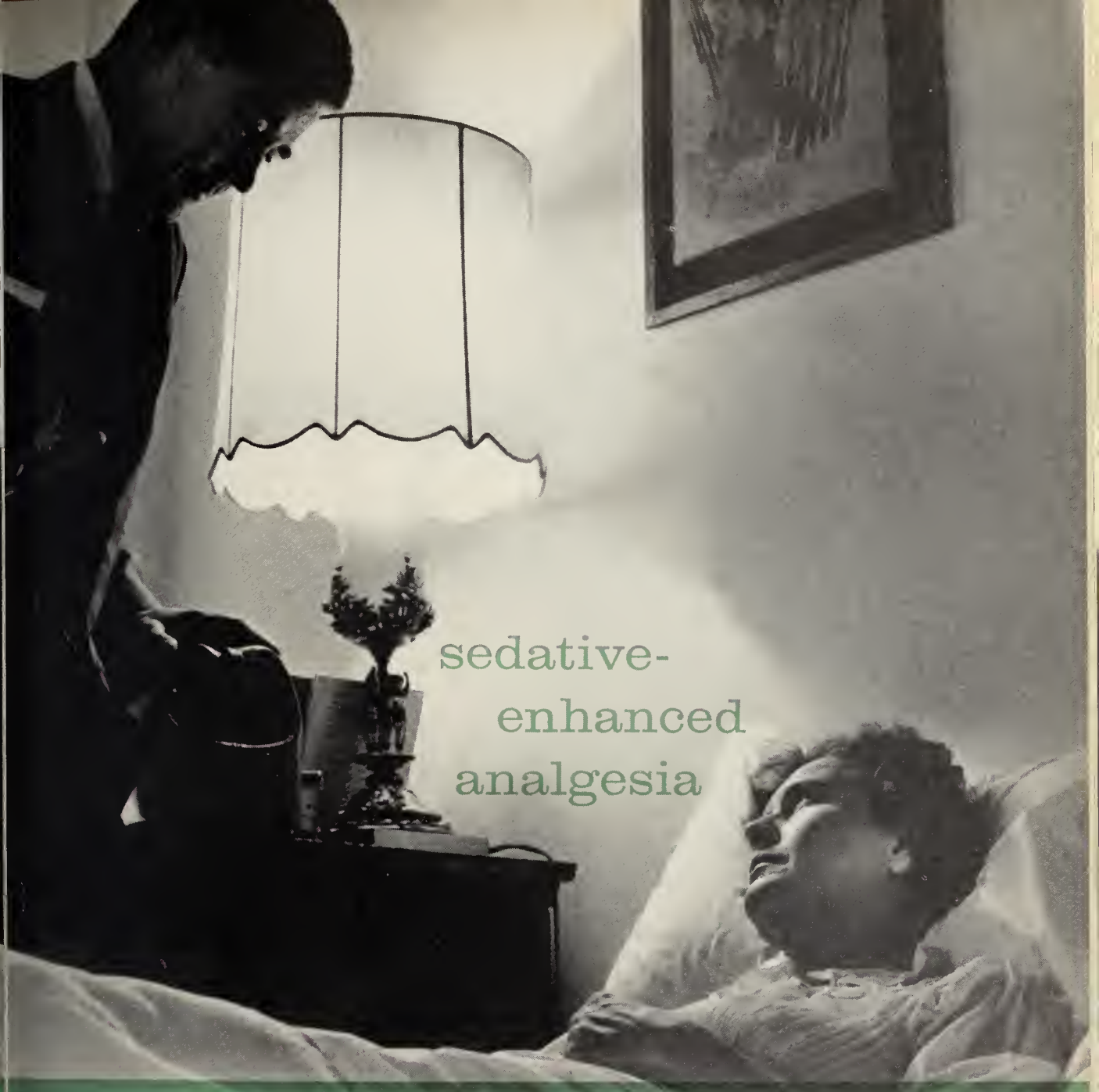
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## New Nonproprietary Drug Names Being Listed

A listing of new nonproprietary drug names began appearing in the November 18 issue of *The Journal of the American Medical Association*.

The AMA through its Council on Drugs, and the United States Pharmacopeia have recently joined forces in a program of selection of nonproprietary names for single entity drugs, i. e., those drugs with a single active ingredient or extracts from a single source.

"The purpose of publishing such a list at this time is twofold: (1) to promptly provide medical educators and physicians with basic and authoritative information on new drugs, and (2) to provide editors of medical journals with a convenient source of formally adopted, nonproprietary names and to encourage their use in these publications," a Journal editorial said.




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Bottles of 100 and 500 capsules.

1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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Obituaries

# Ad Astra

George Michael Blank, M. D., Lorain; University of Pittsburgh School of Medicine, 1920; aged 70; died November 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Blank moved to Lorain in 1921 and continued in practice until his retirement about six years ago. For much of the time there he was physician for the National Tube Division of the U. S. Steel Corporation. He was a past-president of the Kiwanis Club, an elder in the Presbyterian Church and a member of several Masonic bodies. Surviving are his widow, three daughters and a son.

Albert Thomas Cole, M. D., Millersburg; Ohio Medical University, Columbus, 1895; aged 89; died November 13; member of the Ohio State Medical Association and the American Medical Association. A native of Holmes County, Dr. Cole returned there to practice in 1897 after taking graduate work in the East. He was active in his professional work until 1958 when ill health forced his retirement. Among local activities he was a leader in establishing the Pomerene Hospital; was a charter member of the Rotary Club; a member of the Masonic Lodge and the Episcopal Church. Surviving is his son, Dr. Allen A. Cole, of Macon, Ga.

Thomas D. Efstation, M. D., Carlsbad, N. M. (formerly of Tiffin); Georgetown University School of Medicine, 1942; aged 46; died November 9; former member of the Ohio State Medical Association and later a member in New Mexico; member of the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology; member of the American College of Obstetrics and Gynecology. Dr. Efstation practiced in Tiffin from 1950 to June of 1960 when he moved to New Mexico for health reasons. Survivors include his widow, a son, a daughter, his mother, a sister and a brother.

Roy Cooper Ernest, M. D., South Euclid; University of Maryland School of Medicine & College of Physicians and Surgeons, 1931; aged 56; died November 16; former member of the Ohio State Medical Association. Dr. Ernest practiced for about 25 years in the Cleveland area. Surviving are his widow, two sons, a daughter and a sister.

Howard Philip Fischbach, Jr., M. D., Cincinnati; University of Cincinnati College of Medicine, 1942; aged 43; died November 25; member of the Ohio State Medical Association, the American Medical Association, American Society of Abdominal Surgeons; past-president of the Cincinnati Surgical Society. Member of a family of Cincinnati physicians, Dr. Fischbach practiced there for about 15 years. His father was the late Dr. Howard P. Fischbach, Sr., and his grandfather was Dr. Frederick W. Fischbach. Dr. Fischbach, Jr., was clinical instructor in surgery at the University of Cincinnati; he served as state surgeon general with the Ohio Defense Corps and was a member of the Military Order of World Wars. He also was a member of several other professional and fraternal groups and was president of the Order of Symposiarchs. Surviving are his widow, a son, two daughters, his mother and a brother, Dr. William M. Fischbach. Dr. Victor Fischbach, also of Cincinnati, is an uncle.

Will Gilfillan Gardiner, M. D., Toledo; University of Pennsylvania School of Medicine, 1906; aged 81; died November 23; member of the Ohio State Medical Association, the American Medical Association, American Diabetes Association, the Endocrine Society; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. A native of Canada, Dr. Gardiner had been a resident of Toledo for most of his life. In addition to his professional work, he was active in numerous community projects. A former athlete, he was a member of the Coaches Club; also a member of the Chamber of Commerce, Kiwanis Club, Congregational Church. A daughter and a brother survive.

Robert Arthur Gilreath, M. D., Bryan; University of Cincinnati College of Medicine, 1927; aged 61; died November 13; member of the Ohio State Medical Association and the American Medical Association. Dr. Gilreath began practice in Bryan after returning from service during World War II. He formerly practiced in Toledo. At the time of death he was president of the local Board of Health; was also a member of several Masonic bodies. Survivors include his widow, a son, his mother, a brother and a sister.

Robert F. Hiestand, M. D., Cincinnati; University of Cincinnati College of Medicine, 1928; aged 56; died November 11; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians. A native of Springfield, Dr. Hiestand began practice in Cincinnati in 1932. Surviving are his widow, Dr. Helen Hiestand, who is associated with the Cincinnati Health Department; a son, a daughter and two brothers, one of whom is Dr. Richard Hiestand of Springfield.

Earl W. Huffer, M. D., Cleveland; Ohio State University College of Medicine, 1918; aged 69; died November 10; former member of the Ohio State Medical Association; member of the American Uro-

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logical Association; diplomate of the American Board of Urology. Dr. Huffer practiced in Toledo until he moved to the Cleveland area in 1953. He was former president of the Academy of Medicine of Toledo and Lucas County. Surviving are his widow and four sons, one of whom is Dr. Albert B. Huffer, of Dayton; also a sister.

**Samuel Louis Lemel,** M. D., Cleveland; Western Reserve University School of Medicine, 1929; aged 56; died November 27; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology & Otolaryngology, American Otorhinologic Society for Plastic Surgery; diplomate of the American Board of Otolaryngology. Dr. Lemel practiced for about 30 years in Cleveland. In addition to his professional work, he was active in a number of local organizations; was a member of the Masonic Lodge and the Fairmount Temple. Surviving are his widow, a daughter, a son, Dr. A. Lawrence Lemel, of Chicago, and four sisters.

**Hugh J. Leslie, Sr.,** M. D., University Heights, Cleveland; Cleveland College of Physicians and Surgeons, 1911; aged 73; died November 11; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Pediatrics. Dr. Leslie had been a practicing physician of long standing in Cleveland and had recently received the 50-Year Award of the OSMA. Among his activities he had twice served as chairman of the Pediatrics Section of the Cleveland Academy. Surviving are his widow, a daughter, a brother and Jr., two daughters, and three sisters.

**Albert Loveman,** M. D., Cleveland Heights; Western Reserve University School of Medicine, 1919; aged 67; died November 10; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Internal Medicine. A practicing physician in Cleveland for some 40 years, Dr. Loveman was assistant clinical professor of medicine at Western Reserve. Surviving are his widow, a daughter, a brother and three sisters.

**Alfred L. Ludlow,** M. D., Vermilion, Western Reserve University School of Medicine, 1901; aged 85; died November 3; former member of the Ohio State Medical Association. A native and resident of Cleveland during his early life, Dr. Ludlow served from 1911 to 1938 as a medical missionary for the Presbyterian Mission Board in Korea. Formerly on the faculty of Western Reserve and later a member of its Board of Trustees, Dr. Ludlow was honored several times by university groups. Affiliations included memberships in a number of fraternal organizations.

**Edwin Andrew Murbach,** M. D., Archbold; University of Michigan Medical School, 1894; aged 91; died December 2; member of the Ohio State Medical Association and the American Medical Association. Member of a family of physicians, Dr. Murbach devoted his entire professional career to practice in the Archbold area, with the exception of a period of study in Vienna and service in the Army Medical Corps during World War I. He began practice in association with his father, the late Dr. Andrew J. Murbach, and later was associated also with his brother, Dr. Clarence F. Murbach, and his son, Dr. Edwin R. Murbach. Active in church, civic, community and county organization affairs, Dr. Murbach was past-president of the Northwestern Ohio Medical Association. He served for 50 years on the local Board of Education; was one of the original members of the local Park Board and helped organize the Community Commercial and Exchange Clubs and served as president of those organizations. In addition to his brother and son Edwin, he is survived by another son William and two daughters.

**Fred Wilton Reed,** M. D., Cleveland; Western Reserve University School of Medicine, 1923; aged 67; died November 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Reed, after completing his medical education, took intern and residency work in Cleveland and continued to practice there for some 35 years. His specialty was in the field of obstetrics and gynecology. Among affiliations, he was a past-president of the Eastern Cleveland Rotary Club and member of sev-


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eral Masonic bodies. Survivors include his widow, a daughter and a brother.

**Edward Franklin Romig,** M. D., East Cleveland; University of Pennsylvania School of Medicine, 1902; aged 84; died November 7; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Romig opened his practice in East Cleveland in 1904 and retired only about a year ago. Affiliations included memberships in several Masonic bodies, the Canadian Campfire Club and the Hermit Club. Survivors include his widow, two daughters and a son.

**Henry L. Senseman,** M. D., Daytona Beach, Fla.; Ohio State University College of Medicine, 1913; aged 75; died October 29; former member of the Ohio State Medical Association. A native of Miami County, Dr. Senseman practiced for about 25 years in Miamisburg in Montgomery County. Survivors include his widow, two daughters, three sons, a sister and a brother.

**George V. Vernon,** M. D., Akron; Jefferson Medical College of Philadelphia, 1901; aged 84; died November 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Vernon moved his practice to Akron in 1920. He began practice in his native Zanesville and later became a career medical officer with the Army extending that service through World War I. He was a member of several Masonic bodies and the Methodist Church. Survivors include his widow and a son.

# New Members...

The following are the names of the new members of The Ohio State Medical Association since November 1, 1961. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Allen**

William L. Donham, Lima

**Ashland**

Jack E. Irvine, Ashland

**Cuyahoga**

Charles P. Bartley, Cleveland
Daniel K. Bloomfield, Cleveland
Theodore J. Castele, Cleveland
Victoras G. Ceicys, Cleveland
Everett M. Chalker, Cleveland
Alfred Fader, Cleveland
Harry E. Goodman, Cleveland
John E. Hannibal, Jr., Cleveland
Frank R. Hellinger, Cleveland
Robert E. Hermann, Cleveland
James B. Katz, Cleveland
Leonard J. Kucharski, Cleveland
Arnold M. Mitchell, Cleveland
Harry Nudelman, Cleveland
Otto P. Preuss, Cleveland
Elizabeth W. Rauschkolb, Cleveland
Raymond I. Smith, Chardon
Harold R. Tatar, Cleveland

**Lorain**

Joseph A. Nista, Wellington

**Mahoning**

Robert J. Brocker, Youngstown

**Montgomery**

Louis Becker, Dayton
John E. Koehler, Dayton
Michael W. Langello, Dayton
James F. Leary, Dayton
Jacques M. O'Hara, Dayton
Mory Summer, Dayton
John X. Valassiades, Dayton
Richard S. Wegryn, Dayton

**Seneca**

Robert B. Callahan, Tiffin
Leroy J. Cummings, Tiffin

**Summit**

John Jacob, Akron
Franklin H. Swenson, Akron
William J. Williams, Tallmadge


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Surgery of Colon & Rectum, One Week, March 3
Surgical Board Review, Part II, Two Weeks, March 5
General Surgery, One Week, February 26; Two Weeks, April 2
Gynecology, Office & Operative, Two Weeks, April 9
Vaginal Approach to Pelvic Surgery, One Week, March 26
Obstetrics, General & Surgical, Two Weeks, March 12
Pain Relief in Childbirth, 3 Days, March 7
Proctoscopy & Sigmoidoscopy, One Week, March 26
Treatment of Varicose Veins, One Week, March 26
Basic Internal Medicine, Two Weeks, March 26
Basic Electrocardiography, One Week, March 19
Gallbladder Surgery, 3 Days, March 12
Surgery of Hernia, 3 Days, March 15
Urology, Two Weeks, April 2
Surgery of the Hand, One Week, April 16

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# Activities of County Societies . . .

## First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

### CLINTON

Dr. Virgil E. Hutchens this year marks completion of 50 years in the practice of medicine and his family and friends and colleagues in the Clinton County Medical Society gathered to do him honor at a dinner at Snow Hill Country Club, Wilmington, Wednesday night (Nov. 8).

The Ohio State Medical Association also honored him, presenting a certificate and a 50-year pin. Making the presentation was Dr. Charles Hoyt of Cincinnati who asked Dr. Hutchens' son, Dr. John Hutchens, a dentist, to place the pin on his father.

Dr. Foster J. Boyd introduced the guests, Dr. Nathan S. Hale who gave a biographical and character sketch of Dr. Hutchens, and Dr. Robert Conard who made interesting personal remarks.—*Wilmington News.*

### HAMILTON

The Academy of Medicine of Cincinnati in cooperation with the Southwestern Ohio Society of General Physicians presented a symposium on "The Diagnosis and Treatment of Peripheral Arterial Occlusive Disease — Medical and Surgical Aspects," on November 21. Guest speakers were Dr. David I. Abramson, professor and head of the Department of Physical Medicine and Rehabilitation, University of Illinois; and Dr. D. Emerick Szilagyi, surgeon-in-charge, Department of General Surgery, Henry Ford Hospital, Detroit.

In addition to the Academy meeting, a number of Specialty Societies also hold monthly meetings.

Physicians who have served their communities as physicians over a half century were honored at the November 21 meeting of the Academy of Medicine of Cincinnati. Awarded the 50-Year Button and Certificate of the Ohio State Medical Association were Dr. J. Victor Greenebaum, Dr. Louis A. Lurie, Dr. Charles Ascher, Dr. Edgar C. Steinharter, Dr. Charles Hofling and Dr. Giles A. DeCourcy. Other 50-Year physicians unable to be present are Dr. Louis Feid, Jr., and Dr. Francis H. Hutchinson, the latter being a resident of Pasadena, Calif.

### HIGHLAND

Dr. J. Martin Byers, of Greenfield, has been elected president of the Highland County Medical Society for 1962.

Dr. J. C. Bohl, of Hillsboro, was named vice-president, and Dr. David Ayres, of Hillsboro, was reelected as secretary-treasurer.

Dr. Kenneth L. Upp, of Greenfield, is the incumbent president.—*Greenfield Daily Times.*

## Second District

(COUNCILOR: RAY M. TURNER, M. D., SPRINGFIELD)

### CLARK

Dr. George A. Smith moved up to the presidency of the Clark County Medical Society Monday night (Nov. 20) and Dr. Max D. Graves became the president-elect.

In taking over the presidency, Dr. Smith succeeds Dr. D. J. Parsons.

Other officers elected at the annual election meeting held in Hotel Shawnee, include:

Dr. John F. Riesser, secretary; Dr. Harold Fishbain, treasurer, and delegates to the Ohio State Medical Association, Drs. R. A. McLemore, and J. H. Shanklin, and alternates Drs. J. F. Harley and George Fitzgerald.

Guest speaker for the annual meeting was John Moore, chief test pilot for North American Aviation of Columbus. His talk was on the aspects of his work as it concerns the medical field.—*Springfield News.*

### GREENE

Dr. Robert J. Atwell, chief of medical service at the Tuberculosis Hospital, Columbus, was guest speaker when members of the Greene County Medical Society met Tuesday evening (Nov. 14) in the assembly room of Greene Memorial Hospital.

Dr. Atwell's lecture covered a wide variety of aspects on the care and treatment of tuberculosis.

Dinner in the doctors' dining room preceded the lecture which was followed by business meetings of both the Medical Society and the hospital staff.—*Xenia Gazette.*

### MONTGOMERY

Dr. Richard J. Ireton, chief of surgery at the local Veterans Administration center, discussed his experiences with Project Hope at the November 17 meeting of the Montgomery County Medical Society in Dayton.

## Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

### ALLEN

Dr. Frederick H. Wentworth, associate director of the Ohio Department of Health, discussed "Disaster

*(Continued on Page 98)*




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(Contd. from Page 95)

Planning" at the November 21 meeting of the Academy of Medicine of Lima and Allen County.

### VAN WERT

Members of the Van Wert County Medical Society met jointly with those of other professional groups on October 20 to hear a discussion on "The Professional Corporation" as permitted under Ohio S. B. 550. Speaker was Harvey T. Basinger, of Lima.

## Fourth District

(COUNCILOR: EDWIN R. MURBACH, M. D., ARCHBOLD)

### LUCAS

The December schedule of the Academy of Medicine of Toledo and Lucas County contained the following features:

December 1 — General Section — Annual Committee Reports including that of Nominating Committee.

December 7 — Section on Pathology — Symposium on Alcoholism, including among discussants representatives of the Toledo Health Department, Alcoholic Rehabilitation Clinic, Mayors Citizens Advisory Committee on Alcoholism and the Lucas County Academy of General Practice.

December 15 — General Practice Section — Panel discussion on "Modern Trends in Infant Care." Members of Panel: Dr. Frederick Henry, moderator; Drs. Frederic B. Rothman, Marian Rejent, John F. Miller and James C. Roberts.

Other section meetings not scheduled because of holidays.

## Fifth District

(COUNCILOR: HENRY A. CRAWFORD, M. D., CLEVELAND)

### ASHTABULA

The Ashtabula County Medical Society has recently undertaken an educational program of first aid instruction.

The first meeting of this committee was held November 9 at Ashtabula High School. Attending this meeting were members of the Ashtabula Police and Fire Depts. The Ashtabula County Sheriff's Dept., the local members of the Ohio State Patrol and members of the police departments of Geneva, Conneaut and surrounding communities.

Representing the Ashtabula County Medical Society were its president, J. Jason Dixon, M. D.; secretary-treasurer. William B. Millberg, M. D., and the committee chairman, Samuel Altier, M. D.

This meeting is intended to be the first of a continuing series. — *Ashtabula Star-Beacon.*

Dr. Walter T. Lowry, Jefferson, was honored at the November 14 meeting of the Ashtabula County Medical Society with the 50-Year Award of the Ohio State Medical Association. Dr. Henry Crawford, Cleveland, Fifth District Councilor, made the presentation after introductory remarks by Dr. Harry Lynne.

### CUYAHOGA

The 24th annual Lower Lecture, co-sponsored by the Academy of Medicine of Cleveland, the Cleveland Society of Obstetrics and Gynecology and the Cleveland Surgical Society was presented on November 29 following a program at the Academy Headquarters.

The afternoon program consisted of a panel discussion on "Some Aspects of the Problem of Urinary Diversion Procedures." Participants were Drs. Lester Persky, Roger Scott and Rupert Turnbull, with the guest speaker as moderator.

Following dinner at the Tudor Arms Hotel, the lecture was presented by Dr. Eugene M. Bricker, associate professor of clinical surgery, Washington University School of Medicine, St. Louis, Mo. His subject was "Practical and Philosophical Considerations of the Surgical Treatment of Advanced Cancer of the Pelvic Viscera."

### GEAUGA

Dr. Henry A. Crawford, Fifth District Counselor, was a visitor at the regular November meeting of the Geauga County Medical Society held at Chardon Lakes Inn on Friday, November 10, 1961. He discussed the current state and national medical problems with the members.

Dr. Raymond I. Smith, Chardon, and Dr. Arturo Dimaculaguan, Chesterland, were elected to the society. — S. Hayashi, Secretary.

### LAKE

New officers were elected by the Lake County Medical Society at the Annual Meeting held at Lutz's Hotel on Wednesday, November 8.

Elected president was Dr. Maxwell E. Burnham, of Painesville. Other officers are: Dr. Harry A. Killian, Willoughby, vice-president, and Dr. J. G. McClelland, Painesville, secretary-treasurer.

Dr. B. S. Park, health commissioner of Lake County, was re-elected delegate to the Ohio State Medical Association, and Dr. James G. Powell, Painesville, re-elected alternate. Dr. H. S. Wells, of Willoughby, was named a Censor.

Elected to Active membership were: Dr. G. K. Bell, Dr. J. J. Cahill, Dr. R. D. Hochstetler, and Dr. Florence Takacy, of Willoughby; and Dr. A. M. Bringardner, Dr. C. G. Madsen, Jr., Dr. S. G. Rizzo, Dr. L. E. Vanags and Dr. Olga Vanags, of Painesville.

Associate membership was granted to: Dr. J. E. DeMarco, Dr. Nancy L. Tuttle, Dr. Juan C. Ruiz-Bueno, and David L. Farrington; and Non-resident membership to Dr. Daniel Thanos and Dr. J. G. Yared.

Attending as a guest of the society was Dr. Henry A. Crawford, Councilor of the Fifth District.

## Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

### MAHONING

Physicians of the Mahoning County Medical Society treated their medical assistants and secretaries to a dinner and entertainment at their annual medical

assistants dinner, held November 2, at the Mural Room ballroom. The party was for all assistants, whether they belong to the Medical Assistants Association or not, and 146 attended the dinner. Chairman was Dr. S. D. Goldberg, assisted by Dr. Samuel Tamarkin and Miss Dorothy Klein.

The Society opened its second Cultural Seminar for Physicians on November 9, with a lecture by Prof. Victor M. Blanco, Warner and Swasey Observatory, Cleveland, on "Evolution of the Cosmos." The lecture series based on Evolution consists of 14 sessions, held on Thursday evenings from 8:00 p. m. to 10:00 p. m. at St. Elizabeth Hospital auditorium in Youngstown. The series will continue through March 8th, with time off for Thanksgiving and Christmas.

The cost is $15.00 single or $25.00 per couple. Other subjects to be covered in the present series will be evolution of the earth, plant life, animal life, man, society, English language, art, music, science, religion and ideas.

Chairman for the seminar is Dr. Frank Gelbman. Administrators for Youngstown University are Dr. Clair L. Worley, Ph. D., and John P. Gillespie, Dean of Men.

Diabetes Week was conducted in Mahoning County by the Society. There were 207 physicians participating by giving free diabetes checks in their offices and in the hospitals. Distribution of testing material, posters and pamphlets was done by the Woman's Auxiliary. Diabetes Week was promoted by an intensive radio and television spot campaign. Diabetes chairman was Dr. J. D. Miller.

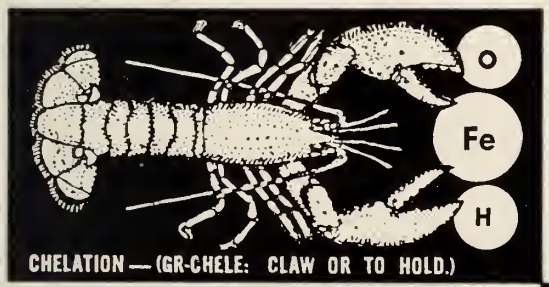
Dr. F. W. McNamara, Dr. Charles Scofield, and Dr. M. S. Zervos were presented fifty-year pins and certificates by Sixth District Councilor, Dr. Robert E. Tschantz, at the Nov. 21 meeting of the Mahoning County Medical Society at the Mural Room Restaurant. The society heard a progress report on the polio mass immunization program for November 30 and December 2 by Dr. Kurt Wegner, chairman of the polio committee. Nominations were made for officers, council and delegates, to be voted upon at the December meeting. Dr. A. K. Phillips, president, presided.

### PORTAGE

The Portage County Medical Society held its annual Ladies Night on December 6, at the Aurora Inn. Dr. Raymond T. Odell of Mantua was presented his fifty year pin by the Councilor, Robert Tschantz, M. D. Following dinner, the group heard an interesting talk by Mr. William Scheele, Curator of the Cleveland Museum of Natural History, on the geological, plant and animal history of northern Ohio.—Don P. VanDyke, M. D., Secretary.

### STARK

"Cancer Detection and Cancer Control" was the program subject for the November 9 meeting of the


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Stark County Medical Society in Mergus Restaurant, Canton. Guest speakers were Dr. Arthur G. James, associate professor in the Department of Surgery and Oncology at Ohio State University, and Dr. John F. W. King, director of the Service Section, Medical Affairs Department of the American Cancer Society.

### SUMMIT

Following dinner, residents of the Akron hospitals presented the December program of the Summit County Medical Society, the following physicians presenting papers as indicated:

Dr. William P. Winkler, "Urinary Tract Infection in Major Gynecologic Surgery."

Dr. William V. Sharp, "Rubber Latex Tubing as a Vascular Prosthesis."

Dr. H. M. Awender, "Subtotal Colectomy and Portal Venous Blood Amonia Concentrations."

Dr. Edwin Meyer, "Pulmonary Lymph Drainage to Thoraco-Cervical Nodes."

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

### BELMONT

The Belmont County Medical Society held its annual Christmas Party at the Belmont Hills Country Club on December 14. Guest speaker for the occasion was Dr. George W. Petznick, Cleveland, President of the Ohio State Medical Association.

## Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, ZANESVILLE)

### FAIRFIELD

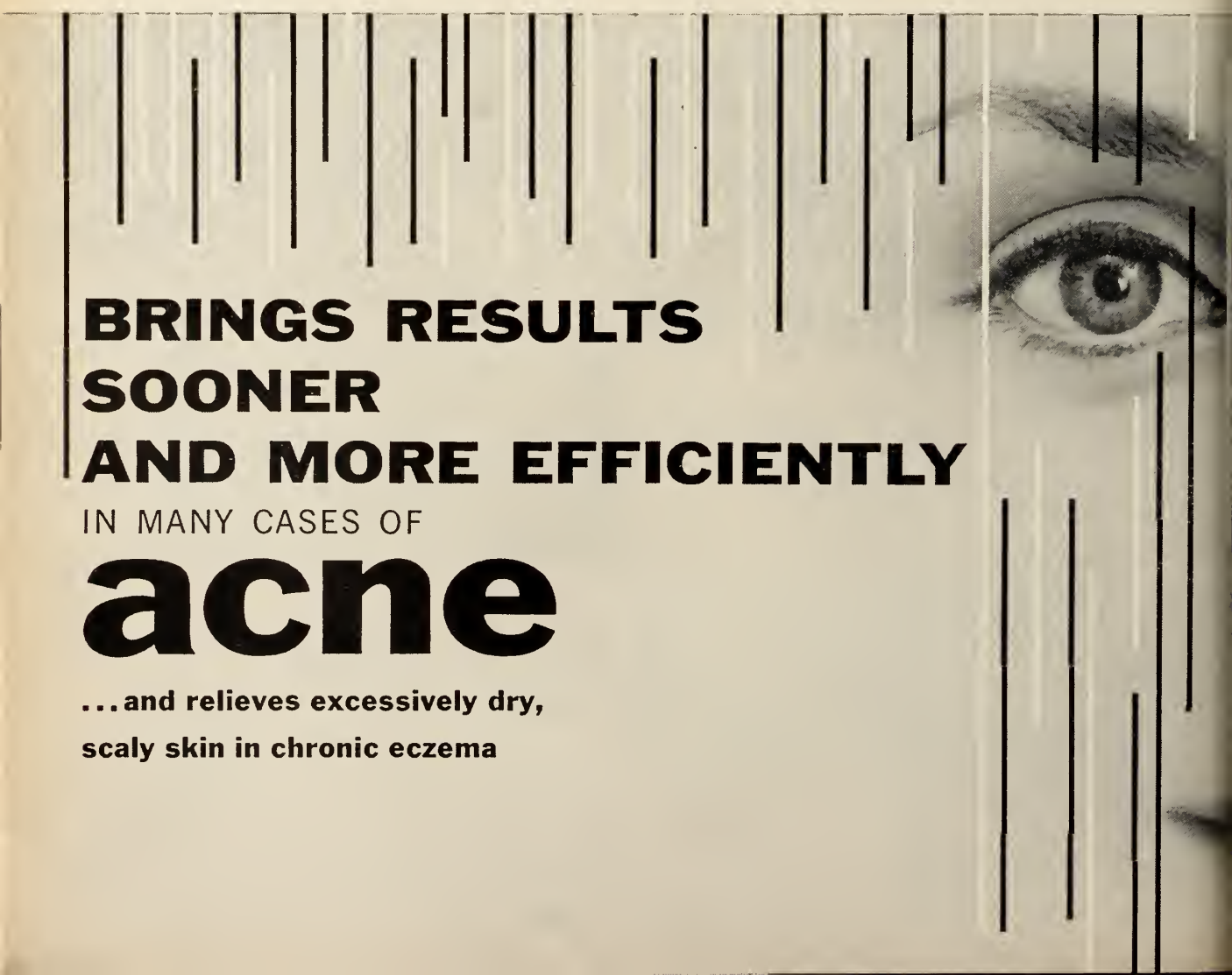
Dr. Robert Zollinger, chief of surgery at Ohio State University, and current president of the American College of Surgeons, returned to his native Fairfield County, where he and Mrs. Zollinger were guests of honor at the November 29 dinner meeting of the Fairfield County Medical Society. The meeting was held at the Lancaster Country Club.

Dr. Zollinger presented interesting experiences on his recent trip to areas of northern Europe including Russia, illustrating his talk with slides.

### GUERNSEY

The Guernesy County Medical Society met at the Berwick Hotel Thursday at noon (Nov. 2). Dr. George Wyatt spoke on "Hypertension Due to Unilateral Kidney Disease."

Doctors Basilio Gonzalez and John Knapp were commended for their role in the recent glaucoma

clinic, having examined 375 individuals and turning up five positive cases of glaucoma.—*Daily Jeffersonian.*

### WASHINGTON

Members of the Washington County Medical Society were guests at meeting sponsored by Judge C. William O'Neill and the Washington County Bar Association at the Castle Club near Marietta on November 6.

## Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

### FRANKLIN

Some 450 persons attended the special dinner meeting and scientific program sponsored by the Academy of Medicine of Columbus and Franklin County on November 20 in the Deshler Hilton Hotel, Columbus.

Concurrent scientific programs were conducted by guest speakers in six specialty fields.

Dr. Thomas R. Curran was introduced as the new President-Elect of the Academy of Medicine of Columbus and Franklin County at the Academy's annual Christmas Banquet held at the Nationwide Inn on December 9.

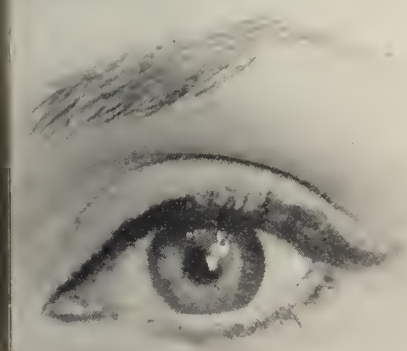
Dr. Curran was introduced by Dr. Donald J. Vincent, president, when results of the by-mail balloting for Academy officers were announced. Dr. Richard L. Fulton, incoming president, will succeed Dr. Vincent in office at the Academy's annual meeting in January.

Other Academy officers elected were: Dr. Chester T. Kasmersky as the new secretary-treasurer; Dr. Horace B. Davidson, Trustee for a four year term; Doctors William F. Bradley and Richard L. Fulton, Delegates to the House of Delegates of the Ohio State Medical Association and Doctors Joseph F. Forrester and T. A. Makley, alternate delegates. Dr. Edwin B. Hamilton was named as an alternate delegate to fill the unexpired term of the late Dr. E. W. Harris.

Another highlight of the banquet featured the presentation of pins and certificates to the following Columbus physicians, who have been in the active practice of medicine for 50 years: Doctors Kenneth A. Clouse and Alexander F. McCoy. Dr. Robert M. Inglis, Academy past-president and Councilor of the Tenth District, made the presentation on behalf of the Ohio State Medical Association.

### ROSS

Dr. Robert E. Swank will head the Ross County Medical Society in 1962. Other officers, all elected in a meeting (Nov. 2) at the Lynne House, are Dr.

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the original aqueous, natural vitamin A capsules

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**faster, more complete absorption** because microscopic aqueous vitamin A particles pass through intestinal barrier more readily...

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**acne · dry skin · chronic eczemas · metaplasia of the mucous membranes · follicular hyperkeratosis · night blindness · lowered resistance to infections**

three separate high potencies (water-solubilized natural vitamin A) per capsule:

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**50,000 U.S.P. units**
**100,000 U.S.P. units**

Bottles of 100, 500 and 1000 capsules.

When vitamin A in high dosage is given for a prolonged period, it is advisable that treatment be interrupted at intervals to avoid possible hypervitaminosis.

James R. Manchester, vice-president, and Dr. David McKell, secretary-treasurer.

Speaker at the meeting was Dr. G. I. Nelson, professor of medicine at Ohio State University. He spoke on "Quinidine." The president, Dr. G. Howard Wood, conducted the meeting.—*Chillicothe Gazette.*

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

Over 120 members and their wives attended the November 14 regular meeting at Oberlin Inn. U. S. Representative Charles A. Mosher and Mrs. Mosher were the guests of honor, and following the social hour and dinner Mr. Mosher discussed the problems presented from the floor for over an hour.

During the brief business meeting Drs. Rose K. Wang, Elyria, and John H. Warner, Oberlin, were unanimously elected to active membership in the Society, and Dr. Joseph A. Nista, Wellington, was elected to associate membership.

Dr. John W. Wherry presented the cause of A. M. E. F. and Dr. H. E. McDonald announced the proposed slate of officers for 1962.

### MEDINA

Dr. N. J. Klotz of Wadsworth was elected president of the Medina County Medical Society at a dinner-meeting of that organization in Wadsworth Municipal hospital (Nov. 16). He succeeds Dr. John Wallace Jr., also of Wadsworth.

Dr. A. J. Karson of Medina was named president-elect, and County Health Commissioner Dr. LeRoy G. Dalheim was re-elected secretary-treasurer. Named to the board of censors was Dr. Richard Avery of Seville, who also enters his second year as a delegate to the Ohio Medical Society. — *Medina County Gazette.*

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### American Thoracic Society Meeting Scheduled

Clinical and laboratory work in tuberculosis and other respiratory diseases will be discussed in three days of scientific sessions at the Annual Meeting of the American Thoracic Society, medical section of the National Tuberculosis Association, in Miami Beach, Fla., May 21-23, 1962.

On the first and third mornings there will be symposiums unopposed by other scientific sessions. The first of these will be on "How Effective Can Anti-Tuberculosis Therapy Be?" and the second will be on "Chronic Bronchitis — An Entity?"

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The Medical Library Association has opened a headquarters office at 919 N. Michigan Ave., Chicago 11, Illinois, and appointed Mrs. Helen Brown Schmidt, as executive secretary.

### More Veterans Being Discharged From Mental Hospitals

A striking increase in the number of Veterans Administration mental patients recovering and leaving the hospital to return to their home communities was reported by the VA.

During Fiscal Year ending June 30, 1961, VA hospitals placed 20,907 patients on trial visit. The number was 7,617 in Fiscal Year 1953, 9,985 in Fiscal Year 1955, 13,200 in Fiscal Year 1957, 16,482 during Fiscal Year 1959, and 17,330 in Fiscal Year 1960.

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### Cancer Research Project

Dr. Donald J. Blaney, instructor in dermatology, is chief investigator in a research project at the University of Cincinnati to confirm finding of Dr. Bertil Bjorklund, of Sweden, who produced antibody responses to cancer in horses. Dr. Vinton E. Siler, professor of surgery, and Dr. Leon Goldman, director of the Department of Dermatology, and director of the University's Cancer Immunology Laboratory at Cincinnati General Hospital, also are working on the project.

An anonymous pharmaceutical firm has made available facilities at its farm and large animal laboratory equipment for the project.


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# Put your low-back patient back on the payroll

*Soma relieves stiffness —stops pain, too*

**YOUR CONCERN:** Rapid relief from pain for your patient. Get him back to his normal activity, *fast!*

**HOW SOMA HELPS:** Soma provides direct pain relief while it relaxes muscle spasm.

**YOUR RESULTS:** With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

This was demonstrated by Kestler in a controlled study: average time for full recovery was 11.5 days with Soma, 41 days without Soma. (J.A.M.A. **172**:2039, April 30, 1960.)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets.
USUAL DOSAGE: 1 TABLET Q.I.D.

*The muscle relaxant with an independent pain-relieving action*

# SOMA®

*(carisoprodol, Wallace)*

Wallace Laboratories, Cranbury, New Jersey

In Our Opinion

# Comments on Current Economic, Social And Professional Problems

### MEDICAL CARE FOR AGED BILL WOULD BE JUST A STARTER

Want to know in which direction we're headed — at least in the opinion of one of the most articulate spokesmen of President Kennedy's pet measures?

*Nation's Business* offers this quote from a statement by Congressman Richard Bolling, Kansas City, Mo., on the medical care for the aged proposal, H. R. 4222:

"It's the most popular issue in the domestic field. In 10 years it will look conservative."

Probably what Mr. Bolling implies is that when and if the U. S. becomes entirely socialized, a system of government compulsory health insurance will only be a part of a big whole.

Those who would prefer to have the U. S. as it is better start getting in their licks against each of the pet programs being dished out by the socializers which in the aggregate, if enacted, would add up to a socialized America.

### DOCTORS NEEDED IN COMMUNITY AFFAIRS

"It is the successful people of the professional and business groups who are the most needed because of their proven abilities obtained from their experience and education" writes Dr. John Quincy Adams, Jr., president of the Ohio Academy of General Practice in *GP News,* in emphasizing why physicians should take part in the running of their communities, government-wise and otherwise.

Truer words were never spoken. Unless the professional and business men do a better of job of pitching in on community activities, the parade is going to pass them by.

### MASSIVE RESEARCH FUNDS CAUSING DISTORTION

One of the most serious questions confronting medical education is pointed up emphatically in the recent annual report of the John and Mary E. Markle Foundation which gives millions to medical education. The report charged that the amount of money the government is giving to support the research programs of medical schools is affecting teaching and other functions of the schools adversely. To quote:

"Because Government grants have concentrated so heavily on the encouragement of research and because medical schools have the facilities and personnel to conduct research, most of the money in the bio-medical field has gone their way. However, medical schools have other and equally important jobs to do, such as training, education and service.

"Research is only one cylinder in the medical school motor. As a matter of fact, medical research itself won't get very far in the future if medical schools are not kept running on all of them. With grants for research projects, research facilities, research trainees, research equipment, research personnel and for anything in any way, shape or form, as long as they are for research, the 'central function' (which is education) and the 'proper internal balance' (among their major responsibilities) of medical schools have been seriously distorted.

"As matters stand, the medical school motor is not hitting on all cylinders and it is in need of a tune-up. Uncle Sam's tinkering is not helping matters very much.

"The overemphasis on research and the consequent distortion of the medical school's function are natural results of the post-war preoccupation with attempts to solve various dreaded diseases by direct attack. This is the popular approach, which has been reflected in the Congress by larger and larger appropriations. Congressional committees have received reams of testimony urging such action — testimony given with the very best of intentions. The action taken by Congress has also been with the best of intentions, for in the area of health especially, they want to do the right thing."

Perhaps, as the report suggests, it is high time for members of Congress to be told of this situation and warned that in the end, research is dependent on education and that both suffer when the fundamental functions of medical schools are thrown askew.

### MARRIAGE COUNSELING BY THE PHYSICIAN

In our opinion, the article by Dr. Philip C. Rond in the *Columbus Academy of Medicine Bulletin* contained some splendid advice for physicians on the matter of marriage counseling. Dr. Rond's comments challenge physicians to meet their obligation in this field; reveal how the physician should function; and when non-medical talent should be called upon to help. Here is what he said:

"Infrequently, fortunately, I receive notices and

announcements to the effect that yet another person or group is ready to provide marriage counseling service. Offering such service in this field has great popular appeal and it is because of this appeal that it attracts referrals from unthinking medical sources. It very often turns out that such referrals by a doctor are his way of rejecting the patient and avoiding offering a service that he more often than not can provide even more effectively than a marriage counselor.

"Marriage problems are problems of individuals as well as problems of interaction. People bring their own personality make-ups into marriage and so dealing with this particular type of problem involves dealing with individuals as well as with a situation. Doctors who treat people objectively do learn to deal with these problems even if they haven't undertaken some sort of study to improve their understanding of people first and the problems which result from their interaction second.

"It seems to me that doctors have an obligation to not make referrals to marriage counselors until they have fully assured themselves that such referrals are really going to be in the best interests of their patients. The marriage counselor is not in any position to 'treat' the doctor's patients. The doctor on the other hand is quite able to 'treat' his patients in any area relating to mind and/or body when he has practiced any length of time. The doctor's approach must include understanding marriage, its effects on the body, as well as the reverse. The use of the clergy in some complementary manner, with close attention to the physical problems, has considerable advantage over trying to disassociate oneself from ones patients' marital problems while trying to deal effectively with their medical-physiological problems.

"In this age of increasing specialization in medicine perhaps it is asking too much to have the doctor include more in his overall approach to his patient, but at least it is seemingly important to try. Do not be misled by the high sounding name appearing in very finely engraved lettering on bonded paper which seems to add status to a service that is being offered. Every physician should, to some extent, be a family doctor, be willing to take time with his people; and be discriminating and self-scrutinizing when planning a referral, especially to a marriage counselor."

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## ARE YOU RUNNING AN "AGGRAVATION CHAMBER"?

James K. Speer, a prominent Los Angeles public relations man, believes that the waiting rooms of some physicians should be termed "aggravation chambers." Commenting on why it is important for each physician to run his office practice on an efficient basis, Speer offers this sound advice:

"I can well understand that it is difficult for a doctor to determine exactly in advance how long it is going to take to give attention to the patient. I believe, however, that:

"An analysis of the average length of time taken for a patient over a period of a week would reflect a more accurate interval to be given between appointments, and

"A little effort and courtesy on the part of the office force in advising patients that they should postpone their appointment for, say, one hour if convenient, or perhaps another day's appointment would be more satisfactory."

He concludes: "I certainly do not believe that socialized or clinical medicine would improve this situation but I am convinced that a lot of other people might be willing to give it a try."

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## PHONE-CALL DIAGNOSIS A RISKY PROCEDURE

A physician who regulary gives free or paid advice involving diagnosis over the telephone may be headed for legal trouble, according to the Law Department of the AMA. It points out that doctors have been sued successfully where the family has relied on a telephone diagnosis which was not on the beam and which resulted in improper treatment of the patient.

Sure, telephone calls can help the physician cut down on house calls, especially in prolonged illness cases but there is a limit to use of this method of keeping in touch with patients.

Physicians who are too busy to provide personal services to those requesting them, should advise those patients to consult another physician.

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## SOME POINTS ABOUT INSURANCE COVERAGES

Do your patients seek your advice on what kind of health insurance to purchase or how good the insurance already owned may be? If so, here are some points you can tell them to look for. They were compiled by the North Carolina State Medical Society:

1. Does it pay the physician for your "first-day" history and physical examination?
2. Does it pay for "pre-existing" illnesses?
3. Are three "waiting periods" for maternity care, tonsillectomy?
4. Does your policy exclude "mental, nervous, and emotional disorders"?
5. Does your policy require a hospital admission simply for x-ray or laboratory studies when you are not actually ill?
6. Is your policy cancellable at the option of the company? Or is it guaranteed renewable?
7. Does your policy allow free choice of physician and hospital?
8. Does your policy contain "age limits," "benefit reductions," waivers, or special premiums?
9. Do you have the right kind and amount of health insurance? Are you over-insured? Under-insured?



## Emotional control regained . . . a family restored . . . thanks to a physician and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances, because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the reassuring fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

**Thorazine®** brand of chlorpromazine
a fundamental drug in both
office and hospital practice
Smith Kline & French Laboratories

SK&F

posed by professional models

## 'THORAZINE' PRESCRIBING INFORMATION

Because of its pronounced calming effect, 'Thorazine' is an outstanding agent for patients with mental and emotional disturbances, particularly those with symptoms of agitation and hyperactivity. In severe cases, initial use of intramuscular administration may be desirable to control symptoms promptly.

Before prescribing 'Thorazine' for other indications than those given below, the physician should be familiar with the dosage, side effects, cautions and contraindications for such uses. This information is available in the *Thorazine® Reference Manual* and *Physicians' Desk Reference*, and from your SK&F representative or your pharmacist.

## ADMINISTRATION AND DOSAGE

Dosage should always be adjusted to the response of the individual and according to the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become troublesome. In emaciated or senile patients, dosage increases should be made more gradually than in other patients.

## ADULT DOSAGE

**Mental and Emotional Disturbances** (e.g., agitation, excitement, or anxiety)—*Starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg. to 50 mg. daily, at semiweekly intervals, until maximum clinical response is achieved. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but some patients may require substantially higher dosages. Discharged mental patients, for example, may require daily dosages as high as 800 mg. *Starting intramuscular dose* is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d.

**Alcoholism—Severely agitated patients:** *Starting intramuscular dose* is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg. t.i.d. **Agitated but manageable patients:** *Starting oral dose* is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, *starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

## CHILDREN'S DOSAGE

**For Behavior Disorders**—*Oral dosage* is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). *Rectal dosage* is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). *Intramuscular dosage* is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day; in children 5-12 years (or 50-100 lbs.)—not over 75 mg./day except in extreme unmanageable cases. In severe cases, higher dosages than those recommended above may be necessary. In such cases, 50-100 mg. daily has been used and, in older children, as much as 200 mg. daily or more may be required.

## IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward because of possible hypotensive effects. The injection should be given *slowly, deep* into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery.

'Thorazine' Injection should not be mixed with other agents in the syringe. Because contact dermatitis has been reported with 'Thorazine', nurses or others giving frequent injections should avoid getting the solution on hands or clothing. 'Thorazine' Injection should be protected from light, since exposure may cause discoloration. Slight yellowish discoloration will not alter potency or efficacy. If markedly discolored, the solution should be discarded.

## SIDE EFFECTS

The drowsiness caused by 'Thorazine' is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine.

Other side effects reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses.

Some patients have an increased appetite and gain weight, but usually reach a plateau beyond which they do not gain.

## CAUTIONS

**Jaundice:** The over-all incidence of jaundice due to 'Thorazine' has been low—regardless of indication, dosage, or mode of administration. It appears to be related to duration of therapy. Few cases have occurred in less than one week or after six weeks. The jaundice that has occurred mimics the obstructive type, is without parenchymal damage, and is usually promptly reversible upon the withdrawal of 'Thorazine'. Although the mechanism is not clearly understood, most investigators conclude that it is a sensitivity reaction in susceptible individuals.

There is no conclusive evidence to indicate that pre-existing liver disease makes the patient more susceptible to jaundice. (Patients with known alcoholic cirrhosis have been treated with 'Thorazine' without further alteration of liver function.) Nevertheless, 'Thorazine' should be used with due consideration in a patient with liver disease.

If a patient on 'Thorazine' suddenly develops fever with grippe-like symptoms, his serum should be tested for increased bilirubin or his urine for the presence of bile. If any of these tests are positive, 'Thorazine' should be discontinued.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

**Agranulocytosis:** Agranulocytosis, although rare, has been reported. Patients should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted.

Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

A moderate suppression of total white blood cells, sometimes observed in patients on 'Thorazine' therapy, is not an indication for discontinuing 'Thorazine' unless accompanied by other symptoms.

**Potentiation:** 'Thorazine' prolongs and intensifies the action of many central nervous system depressants such as anesthetics, barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ¼ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.)

**Hypotensive Effect:** Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If a vasoconstrictor is required, 'Levophed' and 'Neo-Synephrine'* are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

**Antiemetic Effect:** The antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

**Dermatological Reactions:** Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some appear to be due to photosensitivity, and patients on 'Thorazine' should avoid undue exposure to the summer sun.

**Neuromuscular (Extrapyramidal) Reactions:** With very high doses of 'Thorazine', as frequently used in psychiatric cases over long periods, a few patients have exhibited neuromuscular (extrapyramidal) reactions which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug temporarily withdrawn. These reactions can also be controlled by the concomitant administration of an anti-parkinsonism agent (see *Physicians' Desk Reference*). Depending on the severity of the symptoms, suitable supportive measures such as maintaining a clear airway and adequate hydration should be employed. When 'Thorazine' is reinstituted, it should be at a lower dosage.

**Lactation:** Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

## CONTRAINDICATIONS

'Thorazine' is contraindicated in comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.) and also in patients under the influence of large amounts of barbiturates or narcotics.

## SUPPLIED

**Tablets,** 10 mg., 25 mg., 50 mg. and 100 mg., in bottles of 50, 500 and 5000; 200 mg., for use in mental hospitals, in bottles of 500 and 5000. (Each tablet contains 10 mg., 25 mg., 50 mg., 100 mg., or 200 mg. of chlorpromazine hydrochloride.)

**Spansule® capsules,** 30 mg., 75 mg., 150 mg. and 200 mg., in bottles of 30, 250 and 1500; also 300 mg., in bottles of 30 and 1500. (Each 'Spansule' capsule contains 30 mg., 75 mg., 150 mg., 200 mg., or 300 mg. of chlorpromazine hydrochloride.)

**Ampuls,** 1 cc. and 2 cc. (25 mg./cc.), in boxes of 6, 100 and 500. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 6 mg. of sodium chloride.)

**Multiple-dose Vials,** 10 cc. (25 mg./cc.), in boxes of 1, 20 and 100. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 1 mg. of sodium chloride; 2% benzyl alcohol as preservative.)

**Syrup,** 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc. contains 10 mg. of chlorpromazine hydrochloride.)

**Suppositories,** 25 mg. and 100 mg., in boxes of 6. (Each suppository contains 25 mg. or 100 mg. of chlorpromazine; glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated cocoanut oil fatty acids, hydrogenated palm kernel oil fatty acids, lecithin.)

**Concentrate** (for hospital use), 30 mg./cc., in 4 fl. oz. bottles, in cartons of 12 and 36, and in gallon bottles. (Each cc. contains 30 mg. of chlorpromazine hydrochloride.)

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*'Levophed' and 'Neo-Synephrine' are the trademarks (Reg. U.S. Pat. Off.) of Winthrop Laboratories for its brands of levarterenol and phenylephrine respectively.

# Activities of Woman's Auxiliary . . .

CHAIRMAN, PUBLICITY COMMITTEE — Mrs. F. M. Wadsworth, 35 Pinecrest, Mansfield, Ohio.
(Roster of Officers, Page 117)

## ALLEN

The Woman's Auxiliary to the Lima and Allen County Academy of Medicine met November 21, for lunch at the Elks Club. Hostess committee in charge of the meeting included Mrs. James Baker, chairman; Mrs. D. L. Becker, Mrs. T. E. Bilon, Mrs. O. A. Horak, and Mrs. R. P. Epstein.

Mrs. F. Miles Flickinger, Auxiliary president, presided. She gave those present copies of "The Driver's Prayer" and suggested that a copy be attached to the dashboard of everyone's car.

Mrs. J. F. Tillotson, chairman of the club's Safety Committee, was in charge of the program. She introduced Miss Frances Miller, Executive Secretary, Allen County Chapter, American Red Cross, who discussed the scope and training program of her organization.

Health Careers Day was held Saturday afternoon at Memorial Hospital. A total of 130 (75 high school girls, 5 boys, and 50 parents) met at the Memorial Hospital nurses' home. Upon registering and receiving name tags, they were given a list of college scholarships available to Allen County students. Mrs. Thomas Leech, chairman of the Health Careers Committee, welcomed the group. They were served punch and cookies.

A film entitled "Helping Hands for Julie" was shown by Miss Sue Sarber and Miss DeMeril Motter, nursing instructors, followed by a question-and-answer period. The film, made available to nursing and other technical schools by E. R. Squibb and Sons Pharmaceutical Company, demonstrates in narrative form the work done by trained hospital personnel. Several student nurses then took the group on a tour of Memorial Hospital.

Health Careers Day is an annual project sponsored by the Woman's Auxiliary. Committee this year is headed by Mrs. Thomas Leech and Mrs. A. C. Jones.

Sister Mary Raparata, R.S.M., Director of the School of Nursing, was Mistress of Ceremonies for the annual Health Careers Day at St. Rita's Hospital on Saturday afternoon. A total of 207 persons attended — Allen County high school students and their parents.

Sister Mary Edwardine, R.S.M., Assistant Hospital Administrator, welcomed the group and explained Health Careers Day.

## CUYAHOGA

The Chrysanthemum Ball sponsored by the Academy of Medicine of Cleveland and the Woman's Auxiliary was held November 4 at the Carter Hotel in a garden ballroom of pink and purple chrysanthemums. After a buffet dinner, Dr. Leon H. Dembo, acting as master of ceremonies, introduced the entertainers for the evening — all local members — including the following: Dr. Jerome Gross, violin; Mrs. Norman Glazer, Mrs. William Kleinman and Mrs. Nathan Krupkin, dance trio; Dr. John H. Budd, at the piano; Mrs. Middleton Lambright, vocalist.

Mrs. Myron M. Perlich and Mrs. Vincent T. Kaval were chairman and co-chairman of the dance. The ball this year climaxed a week devoted to medical careers which made it possible for high school juniors to look in on the various fields of medicine at 13 hospitals and Western Reserve University Medical and Dental Schools. The ball was well attended, enjoyed by all, and financially will help AMEF.

The monthly board meeting held on November 27, was followed by a luncheon meeting for the members at the Academy of Medicine quarters. A program was presented by Mrs. H. H. Pevaroff on "The Woman and Investments." Members also brought gifts for distribution by Mrs. James P. Winkler to the County Home Senior Citizens. It was also moved at this meeting that the Auxiliary donate to the State Hospitals sports equipment such as practice golf balls, tennis balls, etc.

## FAIRFIELD

Business was the main thought in the minds of the members of the Woman's Auxiliary to the Fairfield County Medical Society, November 13, when they met at the home of Mrs. Gordon Snider, Woodland Drive.

Mrs. R. A. Welsh, Mrs. C. B. Crow, Mrs. G. F. Jones and Mrs. F. W. James assisted the hostess in serving luncheon. Twenty-five members and one guest, the mother of Mrs. Snider, Dr. E. V. Graham of Zanesville, attended the meeting.

Mrs. J. L. Kraker, president, called on the various committee chairmen for reports. Mrs. William Jasper and Mrs. C. B. Crow, brought the members up to date on the activities of the Future Nurses' Club and Medical Careers group in the local High Schools. Mrs. R. A. Welsh gave a report on the Annual Fall Conference of the Woman's Auxiliary to the Ohio State Medical Association. The Fairfield County

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1. Clark, T. E., and Jochem, G. G.: Angiology **11**:361 (Aug.) 1960.

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members voted to contribute $100 at this time to AMEF.

### HAMILTON

"Medicine, Politics, and You" was the provocative subject of the panel discussion featured at the first meeting of the Woman's Auxiliary to the Academy of Medicine of Cincinnati at the luncheon meeting October 16, at the Academy of Medicine headquarters.

Participating were Richard H. Peake, Jr., manager of public affairs for General Electric; Dr. John J. Cranley, Jr., newly-appointed director of medical education of Good Samaritan Hospital, and Mrs. George D. J. Griffin, chairman of the Auxiliary's Legislative Committee. Mrs. Griffin acted as moderator.

"Contemporary Religious Art in Europe" was discussed by Father Kieran Quinn, O.F.M., at the second luncheon meeting of the Woman's Auxiliary to the Academy of Medicine of Cincinnati in the Skyline Room of the Terrace Hilton Hotel on November 14. Father Quinn's lecture was illustrated by slides taken on his recent European tour, with particular emphasis on The Chapel at Ronchamp, designed by Le Corbusier. Mrs. John Mohan was Program Chairman for the day with Mrs. Carl Kitzmiller as her vice-chairman. Hospitality Chairman was Mrs. Howard Pfister with Mrs. Robert McLaurin as her vice-chairman.

The Candelabra Ball, the annual dinner dance, was held on November 18, in the Pavillon Caprice of the Netherland Hilton Hotel. Mrs. Clayton R. Sikes, Jr. and Mrs. James McCord served as co-chairmen. Proceeds from the dance will go to the educational and philanthropic fund, of which Mrs. Charles Hoyt is the current chairman.

### KNOX

Eighteen members of the Woman's Auxiliary to the Knox County Medical Society enjoyed breakfast at the home of Mrs. Donald Walz on November 29.

Mrs. Alexander Mack presented a program on Medical Legislation. A record was played entitled "Ronald Regan speaks out against Socialized Medicine."

The hostess was assisted by Mrs. John Drake and Mrs. Joseph Allman.

The next meeting, January 24, will be held with Mrs. John L. Baube.

### STARK

On October 25, the Stark County Medical Auxiliary members were the hostesses for the Sixth District Meeting. Highlight of the afternoon was the luncheon speaker, Mr. John H. Noble, author and lecturer, who was a prisoner of the communists for 9½ years. The theme of his talk was a warning against taking freedom for granted. He urged his audience not to exchange "The Lord is my Shepherd" for "The State is My Shepherd." Mrs. Wm. White Jr. and Mrs. J. F. Thompson were Co-Chairmen.

On November 21, The Stark County Dental Auxiliary members were our guests at a luncheon meeting. Dr. James Bond, Chief Psychologist at Toledo State Hospital, spoke on "Pattern of Normally Behaved Children." Mrs. Sylvester Centrone was the Program Chairman and Mrs. Hammond Chen was Luncheon Chairman for the afternoon.

We are also pleased to report that the November Benefit Dance netted approximately $800 for the Medical Careers Scholarship Fund.

Our A. M. E. F. project, selling Christmas Cards, was equally successful and we have already passed the $1,000 goal for 1961-62. Mrs. Marling Abel is A. M. E. F. Chairman, Mrs. Richard G. Spitzer is Fund-Raising Chairman, and Mrs. William S. Rothermel is Co-Chairman for this project.

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## Free Choice Given As Deciding Factor

A special article appearing in the November issue of *Monthly Labor Review* draws interesting contrasts between health insurance experiences of select groups of unionists and their families. For his master's thesis at University of California, Burton Wolfman surveyed 100 workers enrolled in a Blue Cross - Blue Shield plan and 100 in a Kaiser Foundation health plan. All 200 belonged to same union. Each group had an average family income of $6,400. Here are some of the author's findings:

Though their monthly premiums were higher, Kaiser families averaged out-of-pocket expenditures of $255 in 1959 for all health costs, including drugs, compared with $312 for "Blue" families. Excluding premium payments, the former spent 2.4 per cent of income for medical and hospital care and the "Blues" spent 3.8 per cent. Although Kaiser families got more for their health dollar, three-fourths of the local union's membership had chosen Blue Cross - Blue Shield.

No. 1 reason given by "Blue" families in explaining their choice of coverage plan was free choice of physician and hospital. The other group, on this point, stressed lower costs and broader benefits.

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## Gastroenterologists Elect Officers at Cleveland

At its recent meeting in Cleveland, the American College of Gastroenterology named as president-elect Dr. Edward J. Krol, Chicago. Dr. Louis Ochs, Jr., New Orleans, assumed the presidency at the meeting. He will be succeeded by Dr. Krol at the 1962 annual meeting in Chicago.

Two Ohio physicians were named to high offices. Dr. Robert R. Bartunek, Cleveland, was elected one of the vice-presidents; and Dr. Stanley S. Sidenberg, also of Cleveland, was re-elected to the board of governors.

# Do You Know? . . .

Dr. Laurence H. Ballou has been named medical director of the Firestone Tire & Rubber Company, with headquarters in Akron, to succeed Dr. Warren L. Hogue who retired November 1 after 32 years service with the company. Dr. Ballou has been on the medical staff of the company for four years.

* * *

Dr. Ralph E. Dwork, director of the Ohio Department of Health, was named to the executive committee of the Association of State and Territorial Health Officers at that organization's recent annual meeting.

* * *

Persons interested in qualifications for certification by the American Board of Obstetrics and Gynecology are invited to contact the secretary: Robert L. Faulkner, M. D., 2105 Adelbert Road, Cleveland 6, Ohio.

* * *

Dr. Ralph M. Patterson, professor and chairman of the Department of Psychiatry and medical director of the Ohio State University Psychiatric Institute and Hospital, has been named president-elect of the Central Neuropsychiatric Association.

* * *

The Mount Carmel Hospital (Columbus) annual Postgraduate Educational Symposium will be held in the auditorium of the School of Nursing on Wednesday, February 28. Full program will be announced later. Chairman of the Symposium Committee is Dr. Thomas R. Curran.

* * *

Cutter Laboratories, Inc., has settled out of court for $1.7 million 15 additional vaccine suits. All but six of some 50 suits against the firm have been settled, involving payment of about $3 million or $1 million in excess of the company's insurance coverage. The suits settled asked for damages in excess of $11 million.

* * *

The State of Texas has announced that it will buy Blue Cross and Blue Shield health insurance coverage for all residents receiving old age assistance if approved by HEW Department. The total monthly premium is reported to be $8.68 per person, making the total cost at this time about $23 million. The program would be effective January 1.

* * *

Office of Vocational Rehabilitation report shows in one year 92,500 disabled persons rehabilitated and employed, and 23,875 brought to "ready for employment" stage.

* * *

It is estimated 1,161,000 persons in the United States use hearing aids; 589,000 men, and 572,000 women, which means that one person out of five with hearing impairment has a hearing aid.

# Coming Meetings . . .

American Medical Association, Annual Meeting, Chicago, June 24-28.

Ohio State Medical Association, Annual Meeting, Columbus, May 14-18.

Central Surgical Association, Cincinnati, February 22-24.

Society of University Surgeons, Cleveland, February 8-10.

American College of Physicians, Philadelphia, Pennsylvania, April 9-13.

### Postgraduate Course In Allergy Scheduled at Pittsburgh

The Section on Allergy of the Montefiore Hospital, Pittsburgh, will present an intensive seven-day course in allergy, May 20-26, inclusive. This course is intended to orient the internist and the general physician in the various phases of allergic diseases. This course also should be of interest to the dermatologist, the rhinologist, and the pediatrician. The registration fee is $85.00. Inquiries should be addressed to Leo H. Criep, M. D., Bigelow Apartments, Pittsburgh 19.

### Steubenville Program

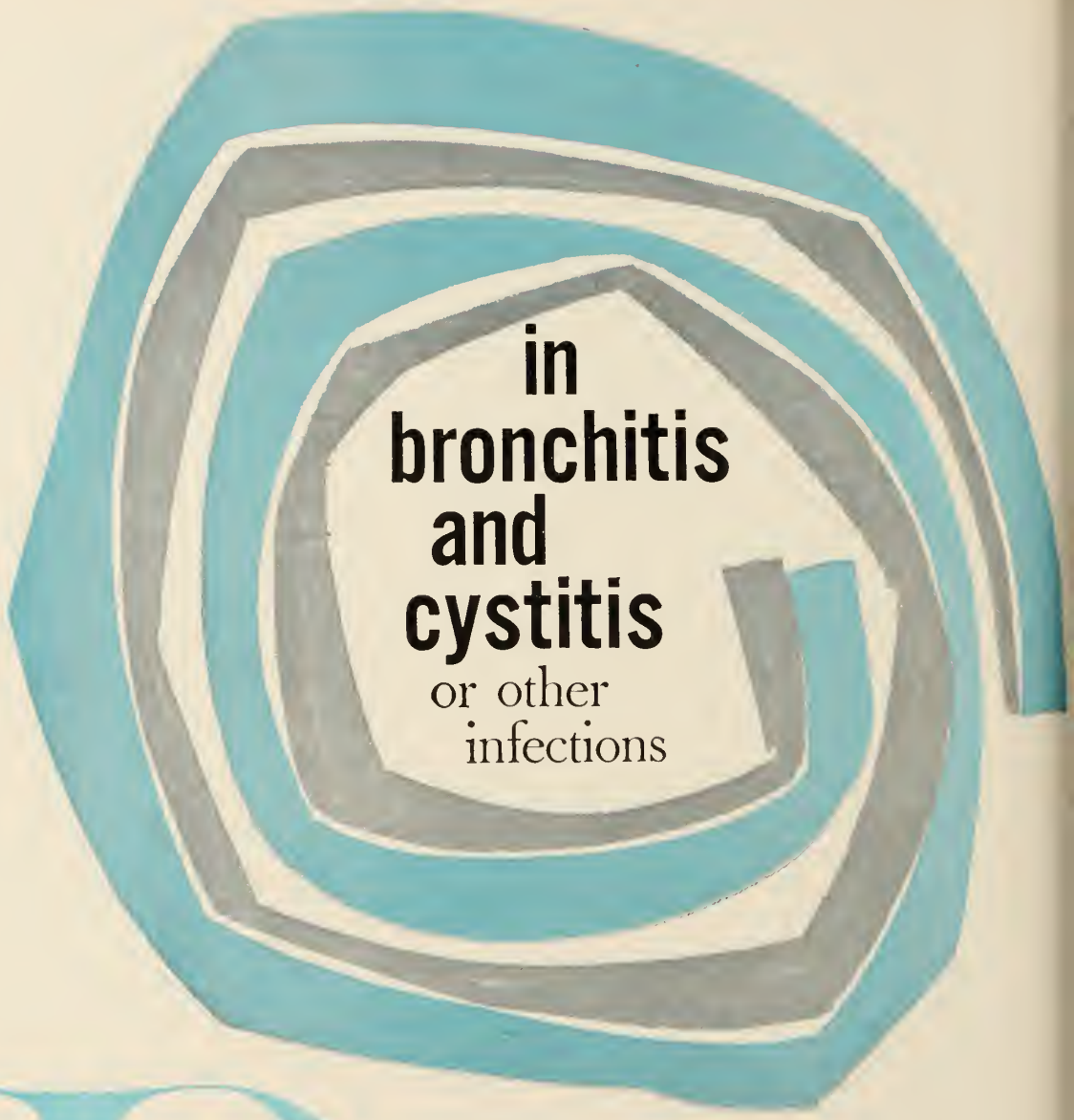
The Fort Steuben Academy of Medicine and the Ohio Division of the American Cancer Society presented a program on "Problems Relating to the Patient with Breast Cancer," on December 12, in Steubenville. The program followed a social hour and dinner. Principal speaker was Dr. Guy F. Robbins, assistant professor of surgery, Cornell University and attending surgeon at the Sloan Kettering and Memorial Center for Cancer and Allied Diseases in New York City.

### Insurance Covers 53 Per Cent

Men 65 years of age or older had some part of their hospital bill covered by insurance in 53 cases out of 100, according to a two-year study released by the U. S. Public Health Service. For women in the same age range, the pattern was similar. Their hospital bills were partly covered in 49 cases out of 100. The study covered the period 1958-1960 and was based on household interviews by the National Health Survey.

### Nursing School Grant

A grant of $3,202 has been received by the Frances Payne Bolton School of Nursing at Western Reserve University from the National Fund for Graduate Nursing Education. The grant is part of the first $100,000 disbursed to 29 accredited graduate nursing programs in 17 states, according to George F. Smith, former president of Johnson & Johnson, Inc., and president of the National Fund for Graduate Nursing Education.




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3. **Manuscripts.** Manuscripts should be submitted in the original on standard 8½"x11" white typing paper. The entire text, including case reports and lists of references, should be typed double or triple space with margins of at least one inch on all sides. A copy of the manuscript should be retained by the Author.

4. **Tables and Charts.** Tables and charts that can be set in type may be included, and there will be no charge for their reproduction.

5. **Illustrations.** Illustrations requiring engraving (photographs, drawings, graphs, etc.) will be submitted to an engraver for an estimate of cost. *The Journal* will assume $25 of this expense and the Author will be billed directly by the engraver for the remainder.

Each illustration should bear the figure number and the author's name on the back. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints. Legends for the figures should be written on separate paper.

Used photographs and drawings will be returned after the article is published, if requested within 30 days after publication. Plates will be sent to the Author after the article has been published.

Obtaining permission for the taking and publishing of photographs, whether or not they are recognizable, is the responsibility of the Author. In case of recognizable photographs, a copy of the subject's signed permission must accompany the manuscript.

6. **References.** Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary. References should be listed in the order of their appearance in the text.

Each reference should include, in this order: Author's last name and initials, title of the article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, month (day of month, if weekly), and year, e. g.

"2. Doe, J. Q., and Roe, R. X.: How to Go About It, Ohio State M. J., 13:24-30 (Feb.) 1920."

Authenticity and accuracy of references are the responsibilities of the Author.

7. **Identification of Patients.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

8. **Reprints.** An order blank for reprints with a table covering cost will be sent with the galley proof to the senior author.

Requests for reprints should be addresssed to the Author.

9. **Editorial Assistance.** *The Journal* Staff is anxious to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as "Medical Writing — the Technique and the Art," by Morris Fishbein, M. D., Blakiston Division, McGraw-Hill Book Company, Inc., 330 West 42nd Street, New York 36, New York.

# COUNTY SOCIETIES' OFFICERS AND MEETING DATES

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ADAMS—Samuel B. Sonkin, President, Main St., West Union; Alexander Salamon, Secretary, Seaman. 3rd Thursday, April, June, August, October and December.

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BUTLER—Paul N. Ivins, President, First National Bank Bldg., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. Last Wednesday, monthly.

CLERMONT—Phillips F. Greene, President, Box 509, Rt. 1, New Richmond; Richard K. Lancaster, Secretary, 684 Batavia Pike-Vermona Drive, Cincinnati 45. 3rd Wednesday, monthly.

CLINTON—Foster J. Boyd, Jr., President, 291 N. South St., Wilmington; Emily B. Buchanan, Secretary, 255 Prairie Ave., Wilmington. 1st Tuesday, monthly.

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HIGHLAND—J. Martin Byers, President, 628 Jefferson St., Greenfield; David S. Ayres, Secretary, 1440 N. High St., Hillsboro. 1st Wednesday, every other month.

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GREENE—Meinhard Robinow, President, 716 Xenia Ave., Yellow Springs; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Tuesday, monthly.

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MONTGOMERY—Charles G. Lovingood, President, 680 Fidelity Bldg., Dayton 2; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Bldg., Dayton 2. 1st Friday, monthly.

PREBLE—E. P. Trittschuh, President, 309 E. Main St., Lewisburg, Birna R. Smith, Secretary, 203 Commerce St., Lewisburg.

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## County Societies' Officers and Meeting Dates (Continued)

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NOBLE—Norman S. Reed, President, 510 West St., Caldwell; Edward G. Ditch, Secretary, 415 Main St., Caldwell. 1st Tuesday, monthly

PERRY—Sydney N. Lord, President, E. Main St., Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

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HOCKING—John W. Doering, President, 42 N. Spring St., Logan; Howard M. Boocks, Secretary, Court House, Logan. Meetings held quarterly.

JACKSON—John L. Frazer, President, 16 N. Ohio Ave., Wellston; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called Meetings.

LAWRENCE—Ralph F. Massie, President, 408 Washington St., Ironton; George Newton Spears, Secretary, 422 S. Sixth St., Ironton. Called Meetings.

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MEDINA—Nevin J. M. Klotz, President, 162 Main St., Wadsworth; Leroy G. Dalheim, Secretary, 220 East Liberty St., Medina. 3rd Thursday, monthly, except July and August.

RICHLAND—C. Karl Kuehne, President, 480 Glessner Ave., Mansfield; Carroll E. Damron, Secretary, 30 S. Mulberry St., Mansfield. 3rd Thursday, monthly.

WAYNE—Robert D. Baer, President, 525 Colonial Ave., Worthington; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday, monthly.

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# Classified Advertisements

Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

**Physicians seeking locations in Ohio** are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where pnysicians are needed, or other physicians who are in need of associates.

EXCELLENT OPPORTUNITY for anyone interested in General Practice in pleasant community of 1,000 population (40 miles northwest of Dayton); house-office combination with equipment; no other doctor in town; reasonable price. Available immediately. Box 199, c/n Ohin State Medical Journal.

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GENERAL PRACTITIONER and INTERNIST — Twenty-man general practice and specialty group in Taconite area of northern Minnesota. Heavy industrial. New hospital facility completed 1960. Unusually liberal partnership agreement. Starting salary up to $1200. Excellent hunting, fishing, skiing area. Contact A. G. Farley, East Range Clinic, Virginia, Minnesota.

INTERNS and 1st YEAR RESIDENTS: $16,000 annual stipend-contract for two years with percentage of gross. Option to remain in group while returning to residency or completion with salary during that period. Upon completion of contract or residency junior partnerships will be offered. Modern clinic being constructed in area equidistant from Cleveland and Akron, allowing city and suburban advantages. Number needed this year 3. Write J. J. Bartolomeo, M. D., Richfield, Ohio.

FOR RENT: Office suite in new building, air-conditioned, on ground floor, ample parking. Located near hospital in community needing additional doctors. Reply Box 253, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER WANTED: The Hollansburg Community 14 miles from Greenville, Ohio, 14 miles from Richmond, Indiana, is seeking a general practice physician. This is a prosperous, rural community. Please contact Village Council.

EXCELLENT, WELL-ESTABLISHED GENERAL PRACTICE available in suburban Cincinnati. Doctor leaving in six months for postgraduate study. Will introduce. Office building, records and equipment available. Box 242, c/o Ohio State Medical Journal.

WANTED: EENT or ENT Specialist to take over recently deceased doctor's highly successful established practice in Cleveland. Office immediately available. For further information please write Mrs. Samuel L. Lemel, 16814 Holbrook Road, Shaker Heights 20, O.

FLUOROSCOPE, PICKER, $250.00; EKG, Sanborn film type, all leads, $75.00. Box 252, c/o Ohio State Medical Journal.

WANTED: Physician for Put-in-Bay, heart of Ohio's Lake Erie vacation area; Township owned office and residence rent free; also subsidy; Port Clinton hospital nearby; 700 permanent residents; 4000 summer season. For further information contact: F. Romer Stoiber, Township Clerk, Put-in-Bay, Ohio.

WELL ESTABLISHED GENERAL PRACTICE in residential community of 7,000, located 30 miles West of Cleveland. Area population of 20,000. Three other M. D.'s in city. Fully equipped office, 1 block from General Hospital. Will sell all equipment; terms can be arranged. Can gross $35,000 to 40,000 first year. Collections very good. Excellent school system. Call Amherst YU 8-8900 or write M. J. Brucker, M. D., 248 Park Avenue, Amherst, Ohio.

WANTED: Orthopedist to join 17-man Ohio Clinic with associated hospitals. Excellent professional and economic opportunity. Part-time teaching and research possible. Please apply promptly. Box 248, c/o Ohio State Medical Journal.

## Announce Preliminary Results In Tuberculosis Study

Isoniazid was 80 per cent effective in preventing tuberculosis among more than 12,000 household contacts of newly discovered cases of tuberculosis, Dr. Luther L. Terry, Surgeon General of the Public Health Service, announced on the basis of preliminary results of one of three field trials begun four years ago and involving 54,000 people in special risk groups. Two local health departments in Ohio are participating in the study.

During the year after a new case was discovered, daily doses of isoniazid taken under medical supervision offered marked protection to household contacts during a period when they were at high risk of developing the disease themselves. Whether this protection lasts is not known at this time, the Public Health Service said.

"We now have evidence that the household contacts of newly discovered cases of tuberculosis can be protected at a time when their risk is highest," Dr. Terry said, "but we do not know whether this protection lasts after they stop taking the drug. The people in the study will be observed for several more years to see whether this protection continues."

The field trials were conducted in cooperation with health departments and hospitals in many parts of the country. In addition to 25,000 household contacts, there were 22,000 patients in mental institutions and 7,000 residents of Alaska villages. Isoniazid was also found to be effective in protecting these groups during the year they were taking it.

The Columbus Department of Health and the Department of Health of Mansfield were among those taking part in the program.

---

Charles C. Croft, D. Sc., has been elevated to chief of the Division of Laboratories of the Ohio Department of Health, to succeed Leo Ey who retired October 31 after 54 years with the Department. Dr. Croft joined the Department of Health in 1949 as assistant chief of laboratories. He has bachelors' and masters' degrees in bacteriology from the University of Maryland and his Doctor of Science degree from Johns Hopkins School of Hygiene and Public Health.

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Of these agents, one author reports: "Chloramphenicol still has the widest and most effective activity range against infections of the urinary tract. It is particularly useful against the coliform group, certain Proteus species, the micrococci and the enterococci."[1] CHLOROMYCETIN is of particular value in the management of urinary tract infections caused by *Escherichia coli* and *Aerobacter aerogenes*.[3] In addition to these clinical findings, the wide antibacterial range of CHLOROMYCETIN continues to be confirmed by recent *in vitro* studies.[4-6]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

*Warning:* Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. *Precautions:* It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

*References:* (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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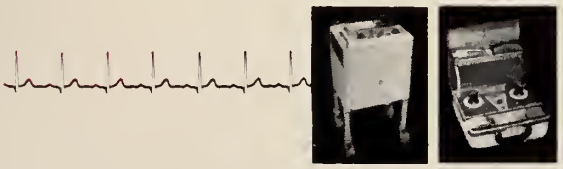
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[1]Hubata, J. A., and Hecht, R. A.: Review of Clinical Use of Hydroxyphenamate (Listica) in 1,759 patients. To be published in Clinical Medicine; [2]Taub, S. J.: Management of Anxiety in Allergic Disorders—New Approach. To be published in Psychosomatics; [3]Cahn, B.: Experience with a New Tranquilizing Agent (Hydroxyphenamate). Ibid; [4]Bergal, M., Beck, C., Davis, O. F., and Sloan, N.: On Use of Hydroxyphenamate in Anxiety Associated with Somatic Disease. To be published; [5]Alexander, L.: Effect of Hydroxyphenamate on Conditional Psychogalvanic Reflex in Man. Supplement to Diseases of the Nervous System, Sept., 1961; [6]Cahn, B.: Effect of Hydroxyphenamate in Treatment of Mild and Moderate Anxiety States. Ibid; [7]Cahn, M. M., and Levy, E. J.: Use of Hydroxyphenamate (Listica) in Dermatological Therapy. Ibid; [8]Eisenberg, B. C.: Amelioration of Allergic Symptoms with a New Tranquilizer Drug (Listica). Ibid; [9]Friedman, A. P.: Pharmacological Approach to Treatment of Headache. Ibid; [10]Greensoan, E. B.: Use of Hydroxyphenamate in Some Forms of Cardiovascular Disease. Ibid; [11]Gouldman, C., Lunde, F., and Davis, J.: Clinical Trial of Hydroxyphenamate in Alcoholic Patients. Ibid; [12]McLaughlin, B. E., Harris, J., and Ryan, E.: Double Blind Study Involving "Listica," Chlordiazepoxide, and "Placebo" as Adjunct to Supportive Psychotherapy in Psychiatric Clinic. Ibid.

*eunoia: A normal mental state (Stedman's Medical Dictionary).

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1. Clark, T. E., and Jochem, G. G.: Angiology 11:361 (Aug.) 1960.

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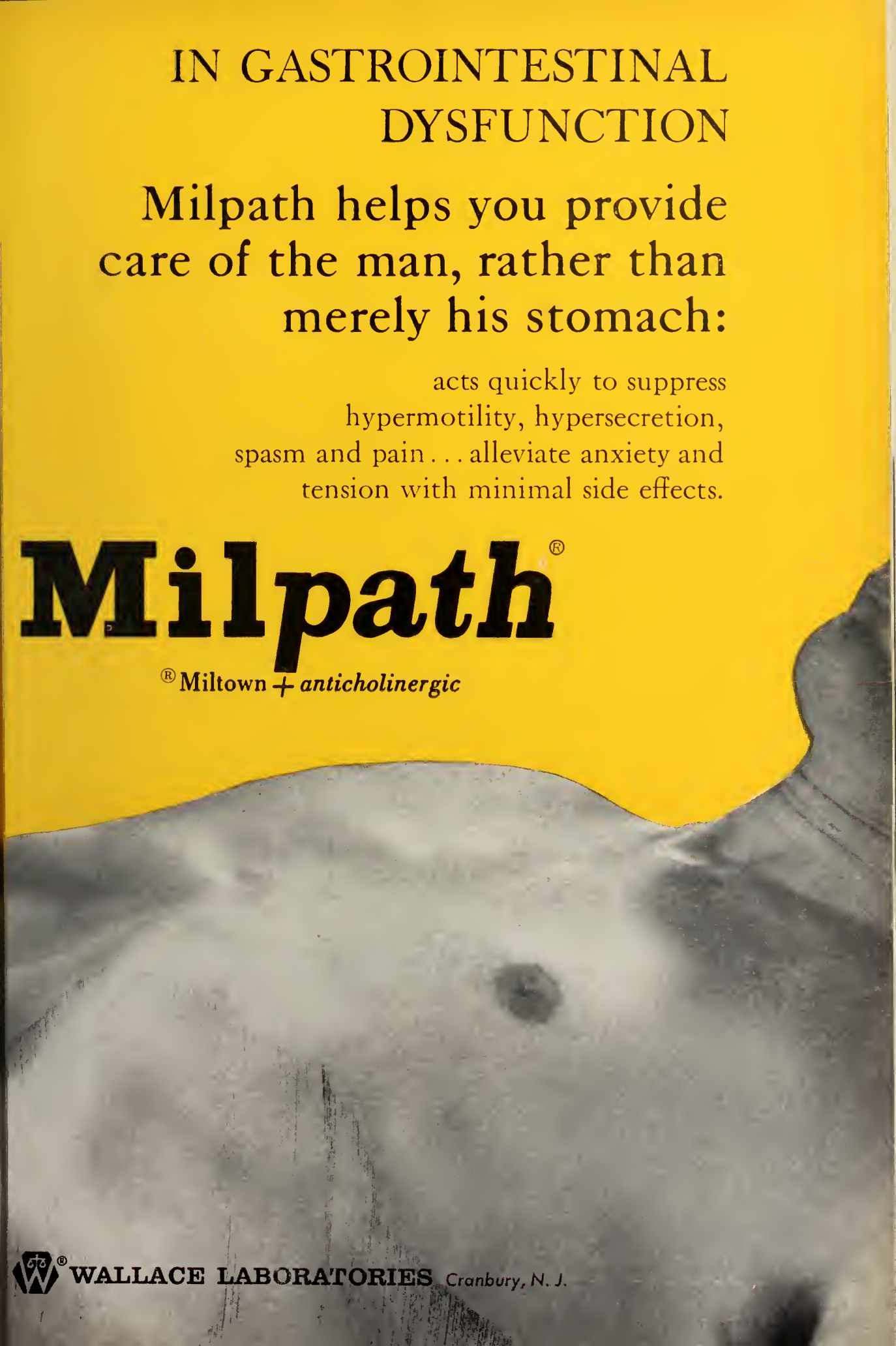
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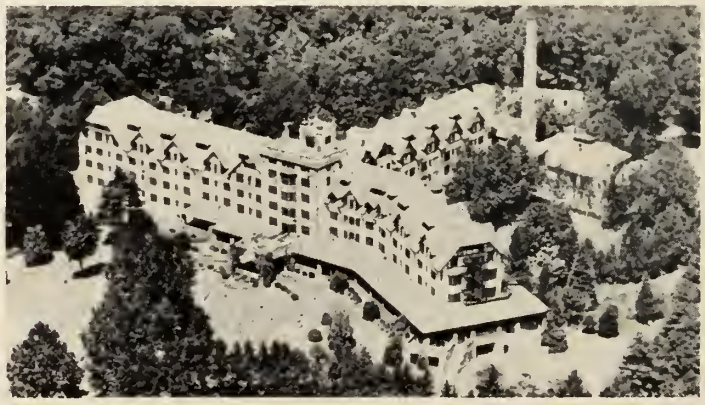



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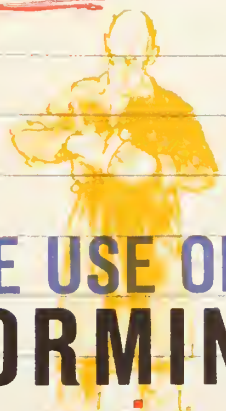


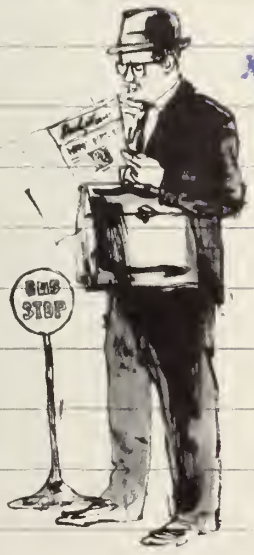

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1. Walker, R. S.: Brit. M. J. 2:405, 1959. 2. Pomeranze, J.: Clinical Medicine 8:1155, 1961. 3. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959.

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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. 2. J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.* July 27, 1957, p. 193. 3. J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. 4. W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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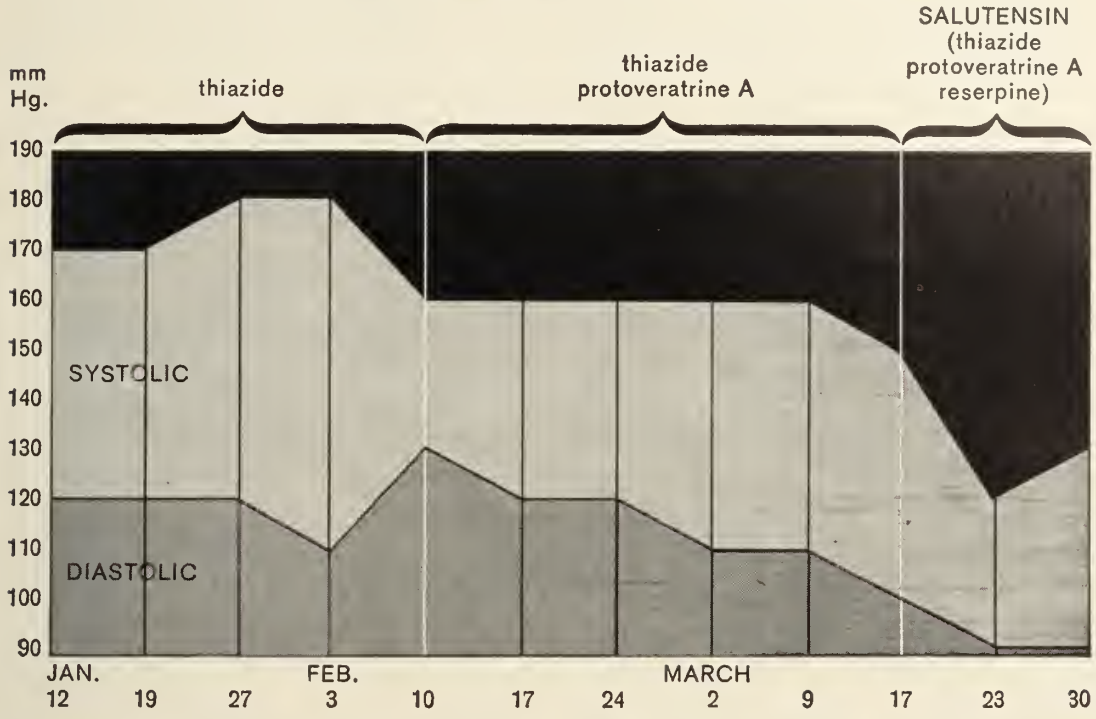
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**References:** 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

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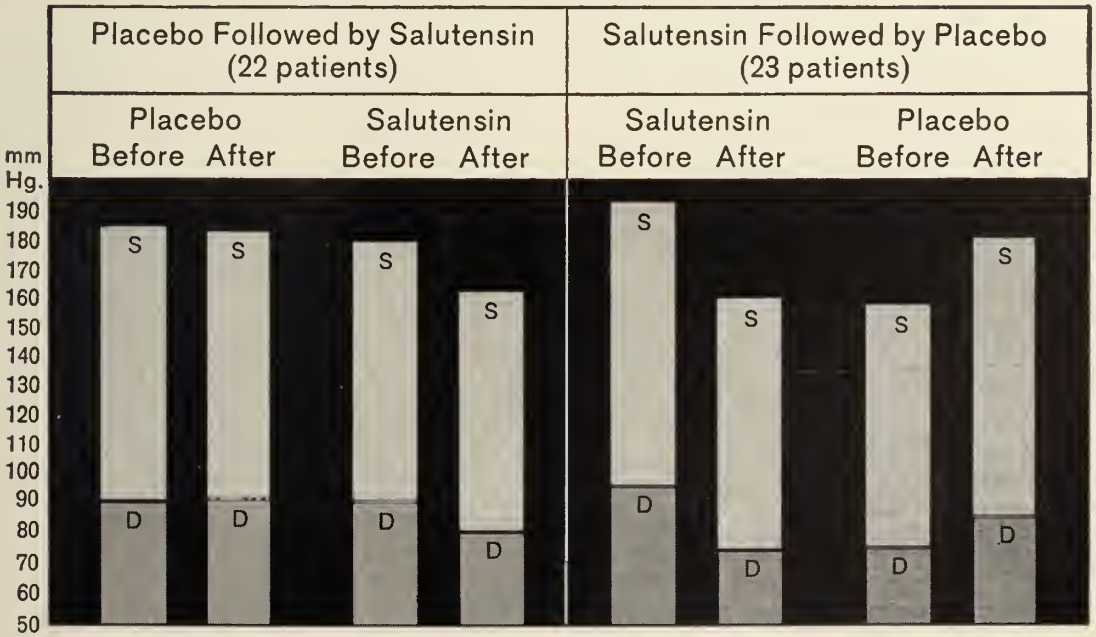
**11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE**

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)




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The reviews are excellent and some of them (e. g. treatment of shock with hypotensive agents) merit the attention of all physicians. The following paragraph concluding the review of cerebral vasodilatation is an example of the exquisite economy of words and clarity of presentation that is evident throughout the text:

"No agent save carbon dioxide can be expected to dilate cerebral vessels preferentially or selectively. Others must be administered in amounts sufficient to produce very marked effects on vessels elsewhere in the body. This in turn is the cause of generalized systemic hypotension which would reduce cerebral circulation time and defeat the purpose of the vasodilatation."

**Medical Pharmacology**, by Andres Goth, M. D. ($11.00, *The C. V. Mosby Company, St. Louis 3, Missouri.)* Written primarily for the student, this book should have value for the practitioner who wishes to review some of the background of current pharmacologic knowledge without being overwhelmed by a detailed listing of drugs and related chemical compounds and their properties. Although he does include essential facts about important drugs, the author stresses principles and concepts that should be helpful in finding our way through the maze of drugs currently available. If practitioners understood some of these principles better, therapy would be more precise and the druggist's shelves less cluttered.

**Experiments in Survival**, compiled and edited by Edith Henrich, commentary by Leonard Kriegel. ($3.50, *Association For The Aid of Crippled Children, New York 17, N. Y.)* This is a series of narratives by 33 physically handicapped people recounting their trials in rehabilitation.

**A Traveler's Guide to Good Health**, by Colter Rule, M. D. ($0.95, *Doubleday & Company, New York 22, N. Y.)*

**Year Book of Dermatology: 1960-1961 Series**, by Rudolf L. Baer, M. D., and Victor H. Witten, M. D. ($9.00, *Year Book Medical Publishers, Chicago 11, Illinois.)*

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**Instructional Course Lectures 1960**, by Fred C. Reynolds, M. D., editor of The American Academy of Orthopaedic Surgeons. ($18.50, Volume XVII, *The C. V. Mosby Company, St. Louis 3, Mo.)*

**Adrenergic Mechanisms;** Ciba Foundation Symposium, by G. E. W. Wolstenholme and Maeve O'Connor, editors for the Ciba Foundation. ($12.50, *Little, Brown & Company, Boston 6, Mass.)*

**Symptom Diagnosis**, by Wallace Mason Yater, M. D., and William Francis Oliver, M. D. ($15.00, Fifth edition, *Appleton-Century-Crofts, Inc., New York 1, N. Y.)*

**The Changing Years: The Menopause Without Fear**, by Madeline Gray. (95 cents, New Revised edition, *Doubleday & Company, Inc., New York 22, New York.)*

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**Your Nursing Services Today and Tomorrow**, by Elizabeth Ogg. (25¢, Public Affairs Pamphlet No. 307, *Public Affairs Pamphlets, New York 16, New York.)*

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**Normal and Abnormal Respiration in Children**, report of the Thirty-seventh Ross Conference on Pediatric Research. Apply, *Ross Laboratories, 625 Cleveland Ave., Columbus 16, Ohio.)*

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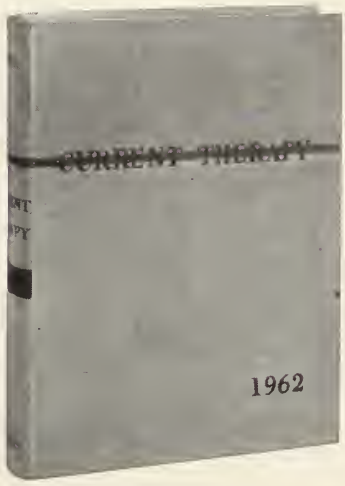
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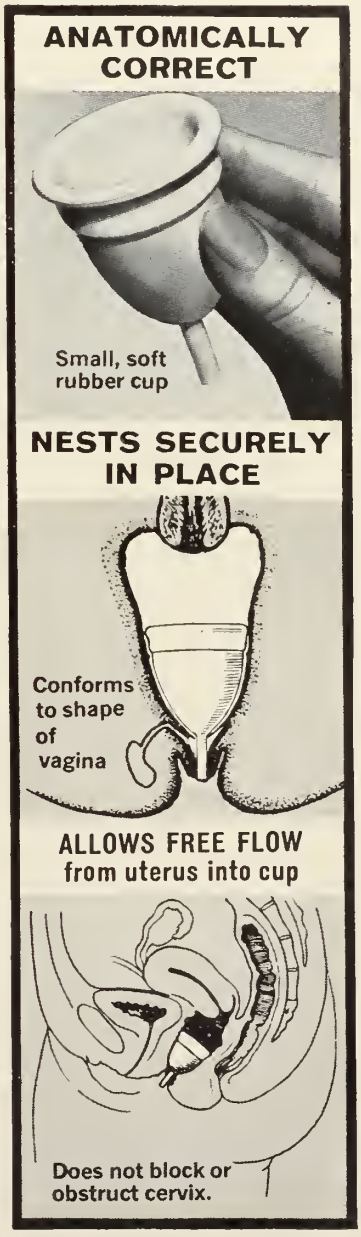
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The Historian's Notebook

# Dr. Frederick Forchheimer

## His Contributions to Pediatrics

J. VICTOR GREENEBAUM, M. D.*

MY PRESENT INTEREST in Frederick Forchheimer has come upon finding a lecture notebook in my recently dismantled office library. Since this is a sketch of Frederick Forchheimer let me state that he was the first Professor of Pediatrics in the Medical College of the University of Cincinnati. I can give only the high lights of a full life, rich in achievement, which influenced the improved health of Cincinnatians and their children. I am also demonstrating Frederick Forchheimer's impact through the passage of the years on today's preeminence of Cincinnati as a pediatric center.

Frederick Forchheimer's name is so intimately associated with internal medicine through his book *The Prophylaxis and Treatment of Internal Diseases,* and his now more renowned *System of Therapeusis of Internal Diseases*** that it may come as a surprise to you to learn of his enduring contributions to the field of Pediatrics.

### Background Training

Practically all of his early contacts on his return to Cincinnati in 1875 from postgraduate pediatric study in Europe in teaching, clinics, and hospital appointments had to do with the care of infants and children. In fact, his book, *The Prophylaxis and Treatment of Internal Diseases*, contains the first organized and systematic outline of preventive procedures in pediatrics. In addition, one is impressed on reading the notes of his first pediatric lectures, given in 1895-1896, by his great competency in this subject. Dr. Frederick Forchheimer was appointed Professor of Pediatrics in 1895. His lectures are the work of a master teacher.

The story of the preservation of these lecture notes is of historical interest. In a previous article[1] I stated that these lectures given in 1895-1896 were the first organized lectures in the West on the diseases of children according to the modern conception. Their preservation for posterity in the Library of the Medical College of the University of Cincinnati and how they fell into my hands, is due to a series of fortuitous events.

In 1915, Dr. Alfred Friedlander, with whom I had been associated for two years, handed me a notebook with a jocular remark that this was a record of how he learned pediatrics 20 years before. He then added the following explanations for the reason of its existence. "He (Forchheimer) gave no examinations after this course of lectures but required his students to hand in their lecture notes." No names were to be signed to these, but a quotation was to be used. Dr. Friedlander's quotation was "Labor Omnia Vincet." This motto is inscribed on the title page.

No grading or comments appear on the notes, but I am certain that Dr. Forchheimer must have been pleased with this student's efforts. The handwriting is clear and the organization of the lectures is comprehensive. By way of an aside I record that Dr. Friedlander's final assignments were Professor of Medicine and Dean of the Medical School.

### Milestones in Medicine

At this point let me call to your attention the medical background of the years these lectures were given. Louis Pasteur, founder of bacteriology, died in 1895, but before his death he had established in his work, *The Germ Theory of Disease,* one of the greatest contributions to medicine. In the same year, 1895, Roentgen discovered the x-ray. Vitamins were not yet discovered nor had viruses been described. Antibiotics were not even a dream. No specific medicines were recognized except quinine for malaria and mercury for syphilis. The diagnosis of diseases was stressed in teaching and practice. Symptomatic treatment was emphasized. Medicine was, for the most part, an art, but great advances in medicine as a science were in the making. During this time Frederick Forchheimer, through his European education, was able to keep up to date with the great advances emanating from the European medical centers and to bring them to Cincinnati. In 1895 he was President of the American Pediatric Society of which he had been one of the founders seven years before.

In order to present in this sketch a clearer picture of this pioneering and gifted physician, I quote liber-

*Dr. Greenebaum, Cincinnati, is consultant, Pediatric staffs of General and Jewish Hospitals; emeritus staff of Children's Hospital, and emeritus Associate Professor of Pediatrics, The University of Cincinnati College of Medicine.

Presented before the annual meeting of the Ohio Academy of Medical History, Granville, Ohio, April 22, 1961.

**This System was published in 1913, revised by Dr. Frank Billings of Chicago in 1914 and by George Blumer of Yale in 1925.

ally from two sources, namely, Charles William Dabney, President of the University of Cincinnati, who knew Frederick Forchheimer intimately, and Borden Veeder, Editor of the *Pediatric Pioneers,* a semi-centennial publication of the American Pediatric Society 1888-1938.

### Chair Dedicated

In Dr. Dabney's address inaugurating the Frederick Forchheimer Chair of Medicine given and published in 1916, he stated in this Memorial three years after Frederick Forchheimer's death:

"Immediately upon returning from graduate study in Europe at the age of 22 (in 1875) Dr. Forchheimer commenced work in the Medical College of Ohio and continued to serve it to the time of his death (1913). In the course of a brilliant career of increasing reputation and service, he was Demonstrator of Histology, Professor of Chemistry, Professor of Physiology and Professor of Pediatrics (one of the first Departments of the kind in America — Harvard Medical School was the first). In 1900 Dr. Forchheimer succeeded Dr. Whittaker in the Chair of Medicine and he was Dean of the College from 1905 to 1909."

. . . and Dr. Dabney added these eulogistic lines:

"Practitioner, consultant, author of many works in scientific medicine, pioneer teacher of pediatrics, member of many learned societies, including the Association of American Physicians of which he was President in 1910-11, Dr. Forchheimer was an idealist, and he was also a Prophet. He was a devoted friend, a great leader, a profound scholar and a wise teacher, but above all of these he was a physician, or as he loved to say, 'Practitioner of Medicine.' "

Dr. Roger S. Morris was the first and only Frederick Forchheimer Professor of Medicine. The onset of World War I and the inability of Dr. Forchheimer's friends to raise the required amount of the endowment for the Chair made it impossible to perpetuate it.

In the *Pediatric Pioneers,* Dr. Borden Veeder wrote:

"Dr. Forchheimer was a distinguished medical man of his generation. His wide knowledge of scientific medicine, his skill as a diagnostician, his knowledge of therapeutics, and his personal magnetism equipped him to practice. He had the privilege of living long enough to see his scientific contributions recognized by medical men throughout the world. He died, as it were, 'among the plaudits of his medical confreres.'

"Dr. Forchheimer studied first in the Ohio Medical School and received his M. D. degree (1873) from the College of Physicians and Surgeons, Columbia University. He did postgraduate work for two years in the Universities of Vienna, Wurzburg, and Strassburg. Returning to Cincinnati, he became the leading practitioner and consultant. He was by nature a teacher, and at the Ohio Medical School, Cincinnati, he taught Anatomy, was Professor of Medical Chemistry and Physiology, and, later, became Clinical and then full Professor of Pediatrics in 1895.

"When the Ohio Medical School united with the Miami Medical College to form the Ohio-Miami Medical College of the University of Cincinnati, he became Dean and Professor of Internal Medicine. He served as Attending and Consulting Physician at the Good Samaritan, The City, and the Jewish Hospitals. He was Physician-in-Chief at the Home for Sick Children, the first hospital of its kind in the West. He contributed many articles to American medical literature. (He translated Hoffman and Ultzman's *Urinalysis;* was the author of *Diseases of the Mouth in Children; Prophylaxis;* and *Treatment of Internal Diseases.* Edited *The Therapeutics of Internal Disease* and contributed to Starr's *American Textbook,* Keating's *Cyclopedia,* and Wilson's *American Textbook of Applied Therapeutics.* He was founder and president of the Association of American Physicians, a member of the American Therapeutic Association, the Washington Academy of Sciences, and other societies.) In 1912, he received an honorary degree of Doctor of Science from Harvard University."

The citation by President A. Lawrence Lowell (Harvard University Archives) follows:

Doctor of Science

"FREDERICK FORCHHEIMER, who in his practice, by his teaching, and with his pen, has contributed to the marvellous advance of medicine in our day; a man in the judgment of his peers worthy to preside over the Association of American Physicians."

Figure 1 is a picture of Frederick Forchheimer as teacher, outstanding physician, and writer. He was even more, a great leader, a man of keen perception




FIG. 1. *Dr. Frederick Forchheimer*

and broad vision. He also had the altruistic urge to help his fellow man, especially the underprivileged infants and children. He gathered around him other dedicated men who carried on as his disciples in the field of preventive pediatrics.

### Pioneer Hospital

In 1879, Dr. Forchheimer was appointed Professor of Physiology and Clinical Diseases of Children and established a Children's Dispensary the following year (1880). He called attention of the local community to the need of special children's hospitals for residential care. In fact, one of his friends and patients, Mrs. Bellamy Storer, one of the old Longworth family, organized, equipped and maintained the first

*(Continued on Page 156)*

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# "nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

**cardiac diseases** "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

**arthritis** "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

**digestive diseases** Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H. Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

**degenerative diseases** "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

**infectious diseases** Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

**diabetes** Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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(Contd. from Page 153)

of such hospitals in 1883 — The Home for Sick Children. Mrs. Storer appointed Frederick Forchheimer as its Director. This was the first such hospital in the West. It was situated in the basin of Cincinnati. No trace of it exists today. Fortunately, however, its first report has been preserved in the archives of the Historical and Philosophical Society of Ohio. In an excerpt included in his medical report of the Home for Sick Children, Dr. Forchheimer wrote as follows:

> "From a medical standpoint, the desirability of establishing such an institution was suggested by seeing the enormous number of sick children which were treated annually at the outdoor clinic (Children's Dispensary) of the Medical College of Ohio. A great many of these poor sufferers were in such a condition as to require a home for their recovery. Before the small hospital on Elm Street was opened, Cincinnati had practically no place for its sick children. True, the City Hospital, the Good Samaritan and St. Mary's had all taken sick children, and still do, when occasion requires, the City Hospital having recently erected a ward for that purpose. Still, speaking from the standpoint of those who are recognized as authorities on this subject, and would see children treated in hospitals erected for that purpose only, the above statement is strictly correct. It was with the object of supplying, as far as it could, this deficiency, that the Home for Sick Children was established."

Children were admitted from birth to the completion of the twelfth year, the limit of age to be extended, if expedient, or if the individual case required it. This home for sick children blazed the trail for the proper care of sick infants and children in Cincinnati. In this his hopes were realized.

At the same time, 1883, the Women's Committee of the Protestant Episcopal Church incorporated a hospital for sick children which it opened in 1884 in Walnut Hills and called "The Hospital of the Protestant Episcopal Church in the Southern Diocese of Ohio." This hospital was the nucleus of the present Children's Hospital and Research Foundation. Frederick Forchheimer as Professor of Pediatrics and Director of the Home for Sick Children was, as I am informed by the public relations officer of The Children's Hospital, consulted by these founding women and gave freely of his time in the establishment of this institution.

## Conclusion

In this brief picture of Dr. Forchheimer and his contributions, I have described the man, his education and his achievements in the fields of Pediatrics and Internal Medicine. His greatest contributions were his emphasis on prophylaxis and his organizing ability as a leader. He exerted, as it were, a catalytic influence on his colleagues and the community. He dedicated his superior talents as physician and educator for the improvement of the health of his fellow-Cincinnatians, especially the infants and children. Thus Frederick Forchheimer lives on in the Medical Hall of Fame.

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EARLY DIAGNOSIS OF CONGENITAL DISEASE OF THE HIP. — The search for a simple effective means for the early diagnosis of congenital disease of the hip continues. At present, the abduction test seems to be the most easily applied test to accomplish this end. It is simple to perform and requires a minimal degree of experience for adequate interpretation.

This report presents the results of use of this test as a screening procedure in 11,010 newborn infants, about 90 per cent of whom were subsequently examined regularly in well-child clinics. With this test, the average age at diagnosis of congenital dysplasia with dislocation was reduced from 14 to 4 months, with no dislocations being undiscovered prior to the weight-bearing age. A negative result of the abduction test at birth does not rule out potential dislocation of the hip. The test should be done regularly during the first 12 months of life.

While of limited value, other clinical signs suggestive of congenital dislocation of the hip should not be ignored. These signs may be of little value in infants with bilateral location.

On the basis of roentgenographic findings the infants were classified as (1) those with congenital dysplasia of the hip with luxation and (2) those with probable congenital dysplasia. — L. E. Harris, M. D., P. R. Lipscomb, M. D., and J. R. Hodgson, M. D., Rochester, Minn.: Early Diagnosis of Congenital Dysplasia and Congenital Dislocation of the Hip. Value of the Abduction Test. *Journal of the American Medical Association*, 173 3:229-233 (May 21) 1960.

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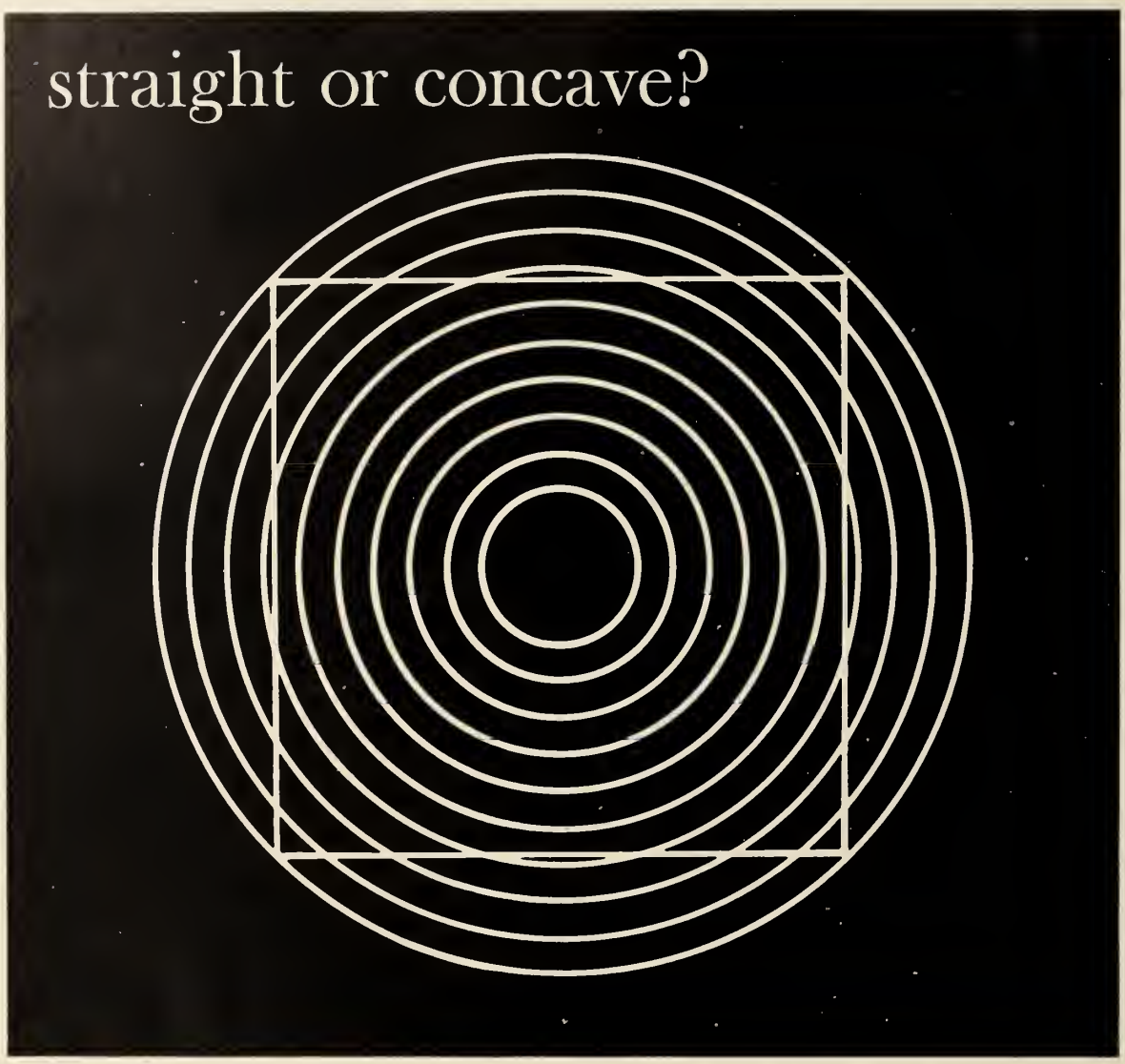
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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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# Juvenile Delinquency and The General Physician

By GEO. E. VOEGELE, M.D., and H. J. DIETZE, M.D.

BOTH the general physician and the pediatrician are more and more confronted with the problem of Juvenile Delinquency. Often the distraught parents, when they are faced with the delinquent problems of their children, do not know what to do or how to cope with the situation. Therefore, they turn for help to their doctor in whom they are used to confiding. Besides being consulted for obvious behavioral problems, the practitioner often becomes aware of undetected illegal and anti-social trends and/or activities during his examination, and he often sees the first step which may end in a full-blown criminal act. Since he has the necessary background information about family and child, he will be in a much better position than anyone else to appraise deviant behavior in the whole context of family relationships. Due to his education and training, the physician is well equipped to understand human problems and detect, diagnose and treat juvenile delinquency. He can prevent many problems of juvenile delinquency in the beginning, thus making referrals to institutions unnecessary in many cases. It is obvious that treatment of the delinquent child has a much better prognosis if started before or in the first stages of puberty.[5]

Juvenile delinquency, in spite of many newspaper reports, is nothing new but there can be no doubt that there is an increase in juvenile delinquency since World War II, particularly in industrialized countries such as ours. This is supported by the findings of the Federal Bureau of Investigation published in the Uniform Crime Reports.[4] From these it can be seen that, though the disorder is still most numerous in big cities, it also grows in rural areas and small towns. Not only the number of juvenile offenses seems to be on the increase, but also the seriousness of individual crimes. One indicator of the loosening of morals and the increase of anti-social activities is, for example, the increase of venereal diseases in juveniles.

Juvenile delinquency is not a disease per se but it is symptomatic of a multitude of underlying physical, social and cultural causes. According to Adelaide M. Johnson's definition, it is "that behavior which is

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From the Juvenile Diagnostic Center, Columbus, Ohio.
Submitted June 23, 1961.

opposed to the tenets held by society and the law in a particular culture,"[1] which when seen in adults would be considered a misdemeanor or felony. It includes a wide range of infractions from truancy, running away from home and disobedience, to vandalism and even murder. In many of these youngsters "dependency or neglect"[8] seems to be an underlying factor.

If we are looking for a common denominator in the wide variety of delinquent behavior, we see that the effect of the psychopathology is a deviant and provocative interaction with society. We see in all of these youngsters an ambivalent self-concept with feelings of inadequacy and insecurity, strong needs for compensation, passive-aggressive conflicts, and all see the world as a hostile place where toughness and aggressiveness are the most desirable assets. Besides psychological, there are biological and sociocultural determinants present in the histories of these delinquents. Reactions to physical shortcomings also might set in motion a chain of reactions leading into delinquency. In addition, investigations done by the Gluecks[6,7] indicate a definite relation between certain body types and juvenile delinquency. Thus a multitude of factors play a role in the development and course of their behavioral disorders.

## Classification

We have to be aware that diagnostic categories of juvenile delinquency are artificial separations made to facilitate our scientific and cultural desire for breakdown and schematization; no such separation exists in life. This is especially true since children and adolescents are not yet fixed in their personality but still in development and transition, and one can frequently see contradictory changes and alterations in their personalities. Thus neurotic-like reactions, psychotic-like reactions, anti-social behavior are seen in sequence of one another and may overlap one another. However, since diagnosis and treatment are inseparably linked and without diagnosis no sound treatment is possible, the following classification was most useful in our work at the Juvenile Diagnostic Center. Through this institution a high proportion of the juvenile delinquents of the State of Ohio are channeled. We felt that this classification might also be the most useful for the practitioner.

We attempted to subdivide the delinquents into the following categories whereby we are fully aware that these diagnostic categories in delinquents are not exhaustive and not mutually exclusive: (1) The individual delinquent; (2) The social delinquent; (3) The organic delinquent; (4) The mentally deficient delinquent.

Since we feel that our cases are representative of the delinquents of the whole State of Ohio, we want to add here the percentage of each of the delinquent groups as we have seen them in the course of one year (July 1959 to July 1960). We have seen 681 boys and girls during that time of whom there were individual delinquents 359 (52 per cent); social delinquents, 236 (35 per cent); organic delinquents, 39 (6 per cent); mentally deficient delinquents, 47 (7 per cent). Our relatively low figure of mentally deficient delinquents might be misleading. Actually these youngsters make up a much higher percentage of the juvenile population who become delinquent. However, many whose deficiency is obvious are sent directly to the State School for the Mentally Deficient.

### I. The Individual Delinquent

In the individual type of delinquent behavior, the problems can be found within the personality of the individual. They are expressions of devious personality development and of serious maturational failures, largely conditioned by undesirable child rearing practices and frustration of basic needs. These youngsters are maladjusted because there is a warped relationship with the most important family members. As a consequence of this, they were arrested in certain aspects of their emotional development. Depending on the stress, the symptomatology might appear in the area of activity as behavioral problems, or in the area of emotions ranging from mild maladjustment to neurosis or even psychosis. Probably the largest group among the individual delinquents belongs to the behavioral disorders. The symptoms might include difficulties with eating, sleeping, bladder and bowel training, control of aggression, education and sexual behavior.

Due to his thorough knowledge of the family, the practitioner is in the best position to evaluate and correct the pathogens in the family. The best way for the practitioner would be to try to understand the patient's problems in the context of the family milieu. He attempts to determine the dominant and most significant personality pattern. He endeavors to understand the deep desires and drives of his patients: How did their aspirations become frustrated, in reality or only in imagination? What part do childhood fantasies play? Under what circumstances did their behavior problems start? Were there any external precipitating events? He tries to understand the deeper meaning of the patient's symptoms and this not only helps him to understand the adolescents better but also indirectly helps the patient to understand himself better. From this it is clear that the practitioner has to have a detailed history of the family and the patient.

The basis of the therapy of the practitioner in these cases must be the establishment of a good interpersonal relation with the patient and his family, and who would be in a better position to establish such a relationship than the family physician! Such a therapeutic approach, which goes beyond what is normally done in an office visit, is naturally time consuming. This factor must be recognized by both the physician and the patient and family.

In the neurotic children and adolescents who show

similar symptoms as adult neurotics, we often have delinquent acts in addition to their neurotic symptomatology. At times these delinquent acts are committed in order to assuage severe unconscious guilt feelings. Psychotic youngsters are often very difficult to diagnose as, particularly during puberty, many signs that in adults would be diagnosed as psychosis cannot be diagnosed as such because of the turmoil of the awakened instinctual drives and the demands the physical growth and emotional maturation make on the youngster. Most psychotic juveniles, if diagnosed as such, belong in the group of schizophrenia. However, one should be careful not to make such a diagnosis unless the cardinal symptoms described by Bleuler (blunting or inappropriateness of affect, ambivalence, loosening of thought associations and withdrawal from the environment) can be distinctly seen. Both these groups need to be referred for psychiatric outpatient treatment or hospitalization if necessary.

The last category of this group, the one which most closely corresponds to the popular image of the juvenile delinquent, is anti-social character disorder. Youngsters with this type of disorder have for the most part a poor prognosis, especially if they are older and their anti-social outlook is already deeply ingrained in their personality. This group of delinquents usually comes from homes in which there has been complete emotional rejection and emotional or physical neglect. Those youngsters therefore grow up markedly hedonistic, unable to form warm emotional relationships with other people and unable to learn from their experiences. They have a low frustration tolerance and need to have their immature drives satisfied whenever they have them, on their terms, without considering other people or the consequences.

These youngsters often make initially a very good impression since they try to belittle their problem and have rationalizations handy to explain everything. They admit only what they know the examiner knows about them and in spite of all their promises, they tend to return to their previous parasitic behavior if they are let loose. Here, the importance lies in recognizing the severe character disorder and referring them to institutional placement since they are not often amenable to drug or psychiatric treatment. Often all that can be done is to remove these youngsters from their environment so that the community will be protected from them.

## II. The Social Delinquent

The group of the social delinquents have the reason for their behavior not within their personalities but in the outer environment.[2] Jenkins,[9] who calls them adaptive delinquents, describes their behavior as the result "of the milieu: bad environmental influence, poor home, and neglect. Thus such a child turns to delinquent peers and identifies with their ideals. Status and acceptance in the delinquent peer group become of paramount importance. Basically, such a delinquent is not different from other 'normal' adolescents except for his company, his ideals, and the delinquent acts. He is also striving towards goals sanctioned by a competitive society although striving by methods legally proscribed."

Because of their poor environment boredom is often present in these youngsters and thus an aggravating factor in delinquent behavior. This boredom is thought to be correlated to the over-stimulation produced by our over-industrialized technical society, e. g. the fast pauseless change of impressions. The overflow of stimuli and the lack of real satisfaction of emotional needs make such juveniles often irritable, and as a result they are constantly on the watch and intent upon new and different thrills. The constant stimulation finally blunts the perceptiveness of the individual and as a consequence he becomes bored and disgusted. Simmel[10] calls this so-called "blasé" attitude a defensive attempt of the individual against the unceasing stimuli of the environment by not showing any reactions any more. This defensive attitude is experienced by the youngsters as boredom. They mention often a reason for their delinquent actions "because there was nothing to do."

Much of this social type of delinquency is based on the need to escape from the self-induced monotony of their life into some kind of adventure; e. g. stealing is done, not out of necessity, but for "fun," or in order to afford some new luxuries. Most of their behavior is an expression of rebellion against the emotional emptiness of modern life. Again the practitioner can be of help to these youngsters by frank discussion, advice to the family, and, through his position as a community leader, he can call in social agencies or other means of environmental manipulation.

## III. The Organic Delinquent

The third subgroup, the organic delinquents, is a rather heterogeneous one. It includes brain diseases caused by traumatic, toxic and infectious agents or degenerative changes, causing either diffuse or circumscribed, reversible or irreversible disturbance of brain tissue functioning. Often the organic impairment is obvious and besides neurological symptoms, the patients show behavior disorder, usually of an aggressive, hostile type. However, there is a large group of patients in whom organicity is not suspected at first since all that these youngsters show is a restless, hyperactive behavior with aggressive outbursts of a violent form. Further study of their background shows that there is a definite history of head injury, anoxia, or brain infection either at birth or later on. The positive electroencephalogram often corroborates the diagnosis made clinically.

There is another group in which we have the same symptomatology but no definite history of brain injury or infection, but studies by electroencephalogram

sometimes show typical dysrhythmia similar to those seen in brain injury. In other cases there is only a nonspecific cerebral dysrhythmia in the electroencephalogram and no other neurological findings detectable with our present examination methods. It is of great importance to establish a diagnosis of organicity in these cases since these youngsters often have been branded as delinquents and criminals because of alleged lack of will power and lack of emotional controls. These patients, however, are not able to establish these controls on their own because of the impairment of brain tissue functioning. However, after the diagnosis is established, often medication remarkably helps these children to control their behavior, which they would not be able to do without medication. Benzedrine® 5 mg. two or three times a day is of benefit in many cases but it often takes several weeks before results are seen. If Benzedrine is of no help, then phenothiazines or other tranquilizers in moderate doses are needed.

Epilepsy might also be one of the causes underlying delinquent acts. In the group of so-called psychomotor epilepsy, we often see aggressive, uncontrollable behavior as an equivalent for the epileptic seizure. To this group also belongs the "epileptic seizures of a bizarre type" which Dr. John R. Hughes and others have described. The psychogenic overlay in the classical grand mal and petit mal epilepsy might also cause reactions which bring the youngsters in conflict with society. These cases, of course, have to be treated as epileptics and the practitioner is quite familiar with their treatment. Nowadays the advent of new anti-epileptic drugs has given him powerful tools to help these disturbed youngsters. The behavior problems will often disappear when the basic illness is brought under control.

### IV. The Mentally Deficient Delinquent

The last group is made up of youngsters who show mental deficiency either of the idiopathic variety or due to organic changes of the brain. They usually have difficulties in school as they cannot keep up with the pace of the class and therefore become dissatisfied, frustrated and, because of the constant demands and pressures that are put on them, they finally turn against their environment in an aggressive way. Also, since they cannot measure up to the peers in their class, they often turn to delinquent groups and gangs in their community because they feel in this environment they will be more easily accepted and they will do anything in order to obtain the approval of these friends. Because of their lack of judgment and poor intelligence, they can easily be led into delinquent and criminal behavior and their lack of the finer discriminatory abilities makes them often unable to see the deviancy of their behavior.

The most important task for a physician would be to detect the mental deficiency of a delinquent youngster in order to be able to take him out of an overdemanding environment. This particularly applies to the mildly deficient youngster whose deficiency is more easily overlooked. Such a child will need special classes. Naturally, if the deficiency is severe, State School or similar facilities for the training of mentally defectives are required. At times the mental deficiency will be obvious; at other times a psychiatric consultation will help to establish the diagnosis of mental deficiency.

Although juvenile delinquency is a community problem and requires cooperation of all available community resources, the first line of defense is the general physician. He is a member of the community, who is intimately in contact with social and family problems and who as a biologically trained physician is concerned with organic changes which might throw an individual into psychopathology of a socially harmful nature. He is best equipped to recognize and deal effectively with these problems or refer them to the appropriate community resources. He also is in the best position to make referrals of the child to the respective agencies through his explanations and his support to the family and child. Due to the trust the family puts in their doctor, they accept a needed referral for psychiatric treatment much better from him than from any other person. Thus, the practitioner can prevent delinquency from getting worse.

Another aspect in the prevention of juvenile delinquency is the physician as an educator, in which he can help the community to find better ways to deal with this problem of juvenile delinquency.

### Summary

The problem of juvenile delinquency has been discussed. A classification is suggested which divides juvenile delinquents into individual, social, organic and mentally deficient subtypes and which is thought to be helpful for the general physician in his dealing with juvenile delinquents. This is particularly important since the general physician is often the first to discover and thus prevent and treat juvenile delinquency.

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# Bacterial Antibiotic Sensitivity Testing: An Office Procedure

ALVIN B. SALISBURY, JR., M.D., and CLIFFORD I. OLT, B.S.

THE ADVENT of commercially available sulfonamides in the late 1930's and penicillin in the mid 1940's promised longer life for people and a different type of medical practice for the physician. The successive appearance of many new and clinically useful antibiotics and chemotherapeutic agents has helped fulfill this promise.

Before the new era was very old, antibiotic resistant bacterial species and strains were discovered.[1] Much has been written concerning bacterial resistance to antibiotics,[2] the mechanism of origin of resistance[2,4] and the changing pattern of prevalent species.[2,4] Of great practical concern to the clinician have been coagulase positive antibiotic resistant staphylococci.[5,6] Equally important today are emergent Gram negative organisms, which were formerly felt to be innocuous saprophytes or symbionts but which have assumed prominence as fatal disease producers during the last few years.[6] While final solutions to these problems have not been found and may not be found in this generation, investigators doubtless will continue to seek those answers which are necessary for workable hypotheses for the practicing physician.

## In Vitro Methods for Susceptibility Testing

Early in the antibotic era investigators devised methods and techniques to determine bacterial antibiotic susceptibility *in vitro*. The basic methods of determining *in vitro* susceptibility, blood and serum levels of antibiotics and minimal inhibitory concentrations for the antbiotics were delineated in the days when penicillin was the only antibiotic available. The validity of *in vitro* determinations as a reflection of probable *in vivo* behavior has been correlated for the antibiotics by clinical experience throughout the world. Newer methods appear to be embellishments or refinements of one of those earlier basic techniques.

Sir Alexander Fleming employed inhibition of visible culture growth and inhibition of metabolic activity to measure the *in vitro* activity of an antibiotic. Later developments in bacterial antibiotic susceptibility testing have utilized one or both of those criteria as a measure of antibiotic activity. However, the search for more efficient and more accurate ways of determining antibiotic activity did not stop with Fleming, and the names of many investigators appeared with their own methods for susceptibility testing.[3] The serial tube dilution method uses inhibition of visible growth to tell whether the antibiotic is effective and the concentration of the antibiotic necessary.[7] The filter paper disc[8] or medicated tablet method[9] and the cup plate method[10] or their variations utilize inhibition of visible growth as the means of detection. A rapid hemoglobin reduction method,[11] and a filter paper method[12] employing triphenyl tetrazolium chloride measure inhibition of metabolic response. (Fig. 1.)

Submitted July 26, 1961.


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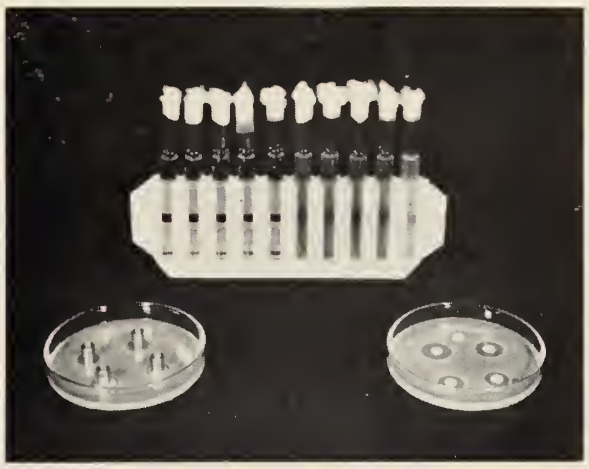



FIG. 1. *Serial tube dilution method, paper disc method and cylinder plate variation of cup plate method for sensitivity testing illustrated. The tops have been left off the petri dishes for clearer illustrations only. The serial tube dilution shown here reveals susceptibility to one antibiotic only with this rack of tubes.*

Armed with an array of over 30 antibiotics and chemotherapeutic agents,[13] the physician has had to rely largely upon his clinical judgment in selecting the agent of choice. He may be wrong statistically

25 to 70 per cent of the time[12,14] but he has never found practical the sending of each patient with an infection to a hosptial or clinical laboratory for bacterial susceptibility testing. Reasons are apparent, including patient reluctance and the possibility of having the patient well before the report is rendered by the laboratory three to four days later (more than half the delay occasioned by travel of the patient to the laboratory, delay in setting up the test, delay in reporting and delay in the mail). The physician, forced to rely upon his experience and clinical judgment to treat infections, generally has confined bacterial antibiotic susceptibility testing to seriously ill, hospitalized patients.

Often the physician has been confronted with the dilemma of having to prescribe a relatively harmful agent for an infection because of the clinical appearance and risk adverse patient reaction and response where a safer agent might have been prescribed and the quandary resolved initially by a bacterial antibiotic susceptibility test.

## Peg Plate Method for Susceptibility Testing

With this background in mind, we have engaged in the laboratory and clinical evaluation of a bacterial antibiotic susceptibility testing device, the Ankh* Plate, which appears to us useful and accurate for laboratory and office practice.

This technique of susceptibility testing has been designated the "Peg Plate Method" to distinguish it from other commonly utilized procedures. Short plastic pegs are used to present the antibiotic or chemotherapeutic agent to the agar. In addition to the Ankh Plate, an incubator and sterile swabs are needed to conduct routine susceptibility tests in the physician's office. A centrifuge is desirable to establish pyuria and to follow the course of urinary tract infections during treatment. It is seldom needed for obtaining an adequate bacterial specimen for initial culture of urines. (Fig. 2.)



FIG. 2. *The equipment utilized by the authors and described in this study.*

*Trade-mark, Ankh Laboratories, Inc.

The plate is a flat, rectangular culture dish made from a clear, biologically inert, polystyrene plastic with inside dimensions of 4 by 82 by 120 mm. Dependent from inside the cover are 11 short pegs with desiccated microcrystalline or amorphous antibiotics of precisely measured amounts on each peg to contact the agar surface for diffusion when the unit is in use.

The top of the dish, on which antibiotic names and concentrations are printed, is packaged in a moisture and vapor proof aluminum foil laminated pouch for protection of antibiotic potency. The bottom of the dish, with prepared agar medium, is packaged with a lid sealed to it by pressure sensitive tape at the periphery.

## Use of Susceptibility Testing

After the agar surface is streaked with the bacterial specimen and the top put on the bottom of the dish, the assembled unit is incubated with the agar surface away from the source of heat to prevent clouding or fogging of the inside of the top with water vapor.

The authors have found that with this test reasonable care is necessary to avoid pressure on the center of the dish since this may force the pegs into the agar surface and initiate fissures which may extend radially in the agar with incubation. These fissures, should they occur, do not invalidate test interpretation since both the fissure and diffusion of the antibiotic follow the same radial pattern.

The time for the appearance of zones of inhibition may be as short as three hours in a few instances, as long as 24 to 36 hours in others; the majority falling between 6 and 12 hours. It is possible to set up a test before mid-afternoon and to have the results before late evening office hours are finished. (Fig. 3.)



FIG. 3. *Closure of the "peg plate" assembly after the agar surface has been streaked with the inoculum. The antibiotics situated on the ends of the pegs, contact the agar surface when the plate is closed.*

## Obtaining Bacterial Specimen

The course or routine followed involves clinical judgment in deciding whether a test needs to be conducted. The following procedures have been found acceptable in the experience of the authors. Urinary

tract infections are routinely tested because of the high percentage of therapeutic failures on a purely empirical basis. These infections are frequently recurrent with different bacterial pathogens in the same patient. Often only one or two agents will be of clinical benefit in a particular urinary tract infection due to the highly irregular susceptibility pattern of many Gram negative organisms, the most frequent offenders in such infections. An attempt is made to culture those middle ear infections where spontaneous rupture of the tympanum has occurred. Chronic or severe infections, including recurrent follicular tonsillitis, chronic bronchitis, furuncles and carbuncles, infected topical ulcers and acute pyodermas are cultured. It is wise at times to culture acute purulent gingival infections.

Acute respiratory infections respond well to penicillin therapy in many instances, but the number of those which do not is great enough to warrant susceptibility testing more frequently than is commonly done. In respiratory infections, the physician may prescribe an adequate course of penicillin or other antibiotic and find that the patient is not well at the end of three to five days' therapy. In the case of Gram negative respiratory infections the mistake in prescribing empirically can be detrimental to the patient. Studies by certain investigators on a purely empirical basis using a very limited number of antibiotics or chemotherapeutic agents (e. g., penicillin, chlortetracycline and a sulfonamide) do not discount the importance of antibiotics in treating upper respiratory infections even though they seem to discredit the usefulness of antibiotics in such instances. Such a study would appear to show the need for a more careful application of antibiotic therapy rather than complete abandonment of antibiotic therapy for the so-called "uncomplicated" respiratory infections.[15]

For urinary tract infections where the overnight specimen is desirable, the patient is provided with a sterile autoclaved bottle with a tightfitting cap and instructed to wash the genitals two to three times before obtaining the urine. The specimen is kept refrigerated to prevent nonpathogenic overgrowth before the susceptibility test can be set up. Because of the high incidence of urethritis and cystitis following catheterization using the best technique (up to 3 per cent),[16] the custom of catheterizing as seldom as possible for obtaining a specimen is followed. In the case of pyuria in the female a careful pelvic examination is done to help ascertain the site and extent of the infection and a vaginal smear is taken to make certain that the pus is not arising from the vagina instead of the urinary tract. Catheterization may be necessary if a purulent vaginal discharge is present and the urinary tract cannot be ruled out.

In the case of a draining ear the portion of the canal through which the sterile swab must pass to obtain the specimen is cleansed with alcohol to attempt to limit the specimen to the pathogen. A similar procedure is followed for furuncles; the skin is cleansed with alcohol to wash off unwanted bacteria, an incision is made to drain the furuncle, and the specimen is obtained from within the furuncle. A throat swab is apt to produce a mixed culture however carefully the specimen is obtained, but the predominant organism will usually be the offending pathogen.

## Clinical Evaluation

Once the specimen has been obtained and the bacterial antibiotic susceptibility test set up, the patient should be evaluated clinically regarding the seriousness of the infection. At times therapy can be delayed long enough to enable the clinician to obtain an *in vitro* indication of a proper antibiotic or chemotherapeutic agent for the infection. This delay may result in saving the patient time and money. In certain instances the gravity of the clinical condition might prompt the physician to prescribe empirically enough antibiotic to treat the patient until the test can be interpreted. When the test is completed, this may or may not be the drug of choice; then the patient can be continued on the drug already chosen, if one of choice, or changed to a drug of choice. The chosen antibiotic should be prescribed at adequate dosage levels for sufficient time to insure recovery of the patient from the disease. This time has usually proved to be two to four days of therapy beyond the time when the patient is afebrile and appears clinically well. In the case of chronically recurrent urinary tract infections some form of therapy may have to be given for 30 to 60 days beyond the time when the urine no longer shows significant pyuria in order to achieve a cure. In these instances urological consultation is advisable.

If a specimen is to be obtained, the importance of obtaining it before the initiation of therapy cannot be overemphasized. Before commencing therapy the clinician has the best chance for obtaining the offending pathogen. Once therapy has been instituted, the agent employed may not have cured the patient clinically but it may be present in sufficient concentration to prevent growth of the microorganism on culture medium. Grove and Randall provide a detailed and excellent discussion of bacterial specimen procurement in clinical infections.[17]

If the physician has been careful in obtaining the culture, he will usually obtain culture growth. There are instances in which an adequate specimen has been obtained and growth is still relatively sparse. However, even in these instances the susceptibility pattern is usually sufficiently outlined to cause no confusion.

An occasional susceptibility test is performed in which no growth is obtained. An occurrence such as this is not wholly unexpected since anaerobic bacteria, certain fastidious bacteria, viruses, and molds require entirely different methods of culture. When this happens, the physician is still confronted with the dilemma of empiricism. However, he has narrowed

the possibilities considerably and ordinarily would not choose one of the narrow range antibiotics, such as penicillin, since most of the organisms responsive to penicillin and other narrow range antibiotics should grow on the ordinary agar surface.

### Diffusion Characteristics of Peg Plate Method

The Ankh Plate has certain features characteristic of peg plate agar diffusion assay procedures. The mode of diffusion is different from that obtained using the paper disc or the stainless steel cup to contain the antibiotic. Both the rate of diffusion and the completeness of diffusion differ. With most antibiotics a larger zone is obtained than is obtained with a similar concentration of antibiotic in the paper disc. All of the antibiotic diffuses from the peg whereas a significant amount of antibiotic is retained by the paper disc due to equilibrium phenomena and physical characteristics of the paper itself.[18] Another factor contributing to the larger peg zone is the more rapid rate in which the antibiotic goes into solution and begins diffusion away from the peg. With the disc water must be drawn initially from the agar to saturate the disc before diffusion begins. This takes time. During this time the organism is beginning to grow, thus narrowing the ultimate zone diameter.

The stainless steel cup used as a container on the agar for an antibiotic solution may have a zone size larger or smaller than that produced by the paper disc, but the zone is smaller than the zone produced by the peg. If a large volume of water is used in diluting the antibiotic, the antibiotic will produce a smaller zone than if a small amount is used for solution. This appears to be due to an already water-saturated agar. In the case of the large amount of water to dissolve the antibiotic (0.2cc. $H_2O$), the nearly water-saturated agar does not allow immediate free diffusion of the water containing the antibiotic into the agar, producing a fairly small zone. In the case of a small amount of water to dissolve the antibiotic (0.02cc. $H_2O$), diffusion of the antibiotic proceeds readily into the agar and a large zone results. Therefore, with equal amounts of available antibiotic, the peg gives the largest zone, the cup with a small amount of water a large zone, the cup with a large amount of water a smaller zone, and the disc the smallest zone.

This characteristic of producing a larger zone due to rapid and complete diffusion from the peg results in a different diffusion curve from that obtained with the disc for each of the antibiotics. The respective diffusion curves of each of these agents does not necessarily behave the same as all others do. The diffusion curves of one antibiotic for the paper disc and the peg may parallel, another may converge in the higher concentrations, and another may diverge, depending upon the specific dynamics of diffusion of the respective antibiotic. (Fig. 4.)

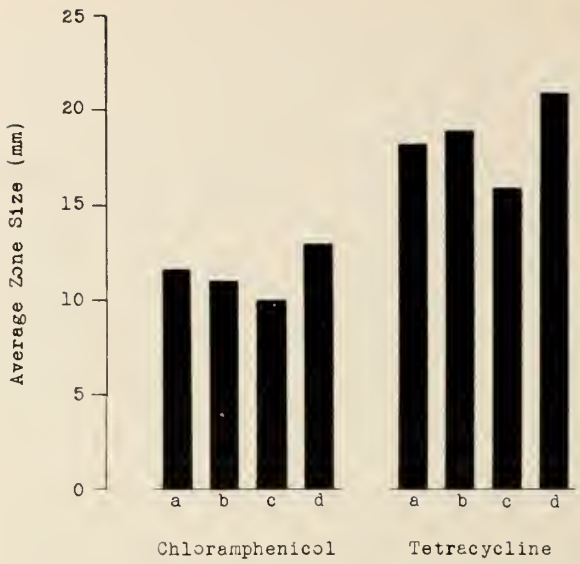



FIG. 4. *Graph showing a characteristic diffusion pattern in agar for chloramphenicol and tetracycline for (a) the paper disc, (b) the cylinder with 0.02cc. $H_2O$, (c) the cylinder with 0.2cc. $H_2O$, and (d) the peg. The antibiotic concentration is 5 mcg. in each instance. Zone diameters are given in millimeters. Test organism in this instance was S. lutea, ATCC 9341.*

Rapid and complete diffusion of the antibiotic from the peg differentiates the peg plate type of agar diffusion bio-assay from the commonly utilized paper disc agar diffusion bio-assay. The availability of all the antibiotic for diffusion into the agar allows this test to approximate more closely the concentration of the antibiotic in the serum and suggests a possible mathematical comparison between agar antibiotic concentration and serum antibiotic concentration. Work along this line of endeavor will be pursued by the authors in the future.

### Convenience of Test Important

Other characteristics of this type of agar diffusion assay come into prominence in describing the test. The factors of convenience, while not the most important for any type of scientific tool, tend to make the device acceptable to the operator. The convenience of the test is important because of time saved the operator and the accuracy of test results. There is less likelihood of introducing a contaminating organism, and less confusion in reading the test results. The name of the antibiotic, concentration of the antibiotic, and the zone of inhibition are readily visible for interpretation of the results and thus contribute to test convenience and accuracy.

In this determination there need be only one variable for the operator: the size of the inoculum. Agar depth, flatness and surface contour, pH, moisture content, vapor pressure overlying the agar chamber and antibiotic content are controlled by the design of the plate and the way it is produced. In the usual petri dish, whether glass or plastic, each of these is a

variable whenever a bacterial antibiotic susceptibility test is conducted.

### Indiscriminate Usage

Criticism has been leveled at the clinician for indiscriminate and unwise use of the antibiotics in treating his patients. At the same time it has been leveled at those who have conducted bacterial antibiotic susceptibility tests without first isolating the organism in pure culure. Although some of the criticism may be justified, most physicians attempt to practice judicious medicine. The so-called "indiscriminate usage" of the antibiotics has resulted in the salvaging of many lives. The performance of a susceptibility test on primary culture may pose certain disadvantages and occasionally result in the suppression of a pathogen. However, the advantages seem to outweigh the disadvantages so frequently mentioned.[12,14]

From a purely scholastic view, bacterial antibiotic susceptibility testing follows bacterial identification. However, at the present time, this practice is difficult and almost impossible in the management of an office practice. Even for the hospitalized patient strict adherence to this rule has been followed less and less. Some laboratories are now reporting susceptibility test results on direct cultures before time has elapsed for isolation and identification of the offending species. This allays the anxiety of the physician by allowing him to commence therapy on a seriously ill patient with less delay than would be entailed with isolation, identification and antibiotic susceptibility testing, in that order.

In office practice the physician and the patient are concerned primarily with results. This may mean returning a man to his job with the least possible time loss at a compatible economic expenditure or it may mean returning a wife and mother to her family with the same economics in view. Seldom are either the physician or the patient concerned with bacterial diagnosis for most frequently encountered infections. If absolute bacterial identification needs to be made, the organism can be obtained from the culture plate utilized for the susceptibility test. (Fig. 5.)

In most instances when a direct susceptibility test is performed on the primary culture, the pathogen causing the disease is present in sufficient numbers to be the predominant organism. In those instances in which two organisms are present in large numbers and grown uniformly on the plate, two distinct sensitivity patterns will be noted by the physician. In such a situation, the choice of antibiotic is confined to one which inhibits both organisms. A combination of antibiotics is chosen logically to combat both organisms if both were not inhibited by a single antibiotic.

There is evidence to support the feeling that direct bacterial antibiotic susceptibility testing is preferred to primary isolation and identification of the organisms with subsequent susceptibility testing on the isolates. The direct susceptibility test offers the advantage of maintaining an approximation of the ecological relationship of the organisms to each other in a mixed culture and may represent a truer determination than the indirect determination after selection, isolation, identification of the pathogen by the operator. The possibiliy is present that a non-pathogen may proliferate to obscure the true pathogen. Also possible is the case in which the growth of the pathogen is enhanced by the presence of an organism which is nonpathogenic at the time. Where a mixed culture is present both organisms will usually grow on an agar surface. The susceptibility pattern of each

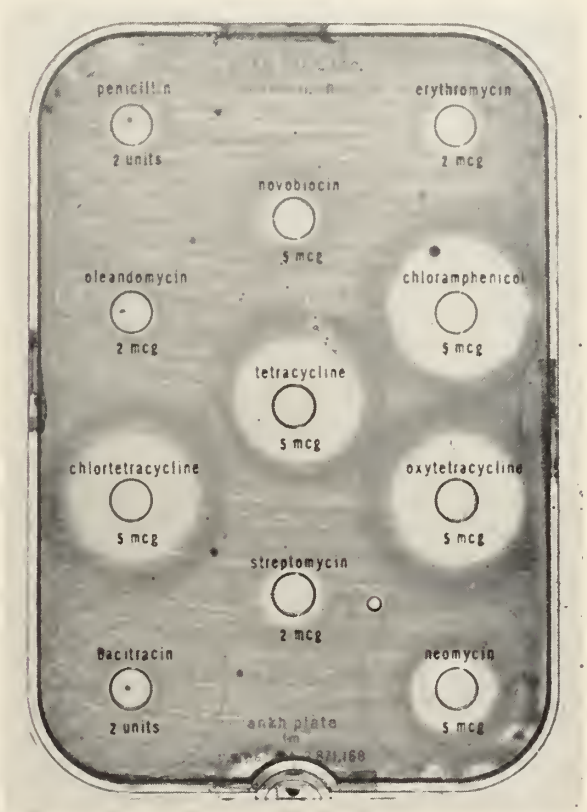



FIG. 5. *Bacterial antibiotic susceptibility pattern demonstrated for a urinary infection. Clear zones around the tetracyclines, chloramphenicol and neomycin indicate sensitivity of the organism to those antibiotics. Careful examination will reveal that this is a streaked plate though the uniformity of streaking almost gives the appearance of a seed layer.*

is generally discernible, and usually at least one or two of the antibiotics will be active against both organisms. Occasionally a combination of antibiotics or chemotherapeutic agents is indicated by the entirely different susceptibility patterns of the two organisms. Problem cultures like these are not so enigmatical after the physician has experience with bacterial antibiotic susceptibility testing.

### Summary

A new method for bacterial antibiotic susceptibility testing is described. This method is embodied in the Ankh Plate. The advisability of conducting such

tests to enhance the basis upon which clinical judgment can be exercised is given. The ease of use of the Ankh Plate in office practice is emphasized. Certain problems confronting the physician in antibiotic selection and in treating infections in office practice are reviewed.

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CULTURAL CONFLICTS RESULTING FROM IMMIGRATION were studied in five adult male patients all born within one year of the parents' arrival in this country. The variable of having been raised in two cultural settings concurrently is seen as having particular effects on the family and to lead to certain specific characterological features of the second generation immigrant patient. These patients were confronted with a conflict between the standards of the family and those of the society into which they had been born. The choice was not an easy one because the adoption of the attitudes of the new culture was equivalent to displeasing the family. Older brothers or sisters, born in Europe, also had difficulties but instead of condemning their background, they were critical of their new surroundings. However, they were able to adjust to the new customs even though they did not agree with them.

On the other hand, the patients were sometimes completely rejected in their attempts to identify with a group, or, in most instances, were retained in an inferior capacity and continually ridiculed. Although it was a blow to their self-esteem, they seemed to accept the clown role without outward protest and went further by burlesquing the mannerisms and accents characteristic of their background. One would have expected considerable anxiety as a result of these conflicts, but instead these patients displayed an air of calm and an objectivity and perceptiveness that seemed to be mature reflection. The patients described themselves as having been serious and pensive children. The preponderance of these traits of clownishness and pseudo-maturity was striking among the five patients. The same pattern of reaction persisted into adult life and most of these patients sought help when this particular inconsistency in their behavior produced problems of social maladjustments. — *(Abstract):* Peter L. Giovacchini, M. D., Chicago: *A. M. A. Archives of General Psychiatry,* July, 1961.

# Serum Glutamic Oxalacetic Transaminase Levels

## A Study of Changes Occurring After Transurethral Resection of the Prostate

DAVID E. ROBINETTE, M. D.

THIS STUDY represents an attempt to determine the change if any, in serum transaminase levels in patients undergoing transurethral prostatic resection. The initial concept of such a change occurring and the motivation for this study were the events observed in a patient who had this operation performed because of progressive urinary retention.

### Case Report

A 65 year old white married man was first admitted to the urology service at Mercy Hospital, Springfield, Ohio, on August 25, 1959, with a chief complaint of "difficulty voiding" for approximately six weeks prior to admission. He gave a history of gradually progressive frequency, hesitancy, nocturia, and decreased urinary stream for about five years. Two years prior to his present admission he experienced an isolated episode of gross hematuria, but he did not consult a physician. He denied any recurrence of this hematuria. There had been a marked increase in all symptoms over the six weeks prior to admission but complete retention did not occur.

He had never been hospitalized or required medical assistance prior to this admission. The review of systems was noncontributory. He specifically denied any cardiovascular or pulmonary symptoms. *Physical Examination:* The blood pressure was 170/110. There were grade II arteriosclerotic changes in the fundal vessels. There was a sinus bradycardia at 56 beats per minute. No heart murmurs were heard. There was cardiac enlargement to 2 centimeters left of the midclavicular line. The liver was palpable 2 centimeters below the right costal margin and was firm, regular, and nontender. The prostate gland was enlarged two and one-half times normal size with the right lobe stony hard and irregular. The remainder of the physical examination was normal. *Laboratory reports* were all within normal limits except for an electrocardiogram which was abnormal with primary T-wave changes probably arising from the anterior wall.

On August 28, 1959, the patient underwent a transurethral resection of the prostate without difficulty or immediate complication. On the following day he experienced a brief episode of syncope when assisted into a chair for the first time postoperatively. By the time he was examined by a physician, he was back in bed, alert, and having no discomfort. He denied any symptoms at that time. The blood pressure and pulse were unchanged from preoperative values. The respirations, color, and skin temperature were normal. A hematocrit, hemoglobin, and white blood cell count were normal. The electrocardiogram revealed no change from the preoperative findings. Following this, the patient had a normal clinical recovery with no further symptoms suggestive of cardiovascular disease. Electrocardiograms on the two succeeding days revealed no change on the first day, but the previously noted T-wave changes reverted to a normal pattern on the second day and remained normal until discharge.

Daily serum glutamic oxalacetic transaminase levels were as follows:

| | |
|---|---|
| August 30 | 10 Units |
| August 31 | 54 Units |
| September 1 | 30 Units |

The normal range for this enzyme in our laboratory is 1 to 45 units.

The elevated transaminase without other evidence of myocardial damage led us to wonder if perhaps the resection of the prostate or the bleeding prostatic bed and subsequent hemolysis were sufficient to cause the elevation noted. Therefore the decision was made to conduct the present study.

### Material and Methods

All patients undergoing transurethral resection (TUR) of the prostate during the next few weeks were used as subjects for this study. No attempt was made to exclude patients with coexistent disorders. Likewise, no special diagnostic, preventive, or therapeutic measures were employed unless they were specifically indicated.

Four urologists performed the operations, and all used isotonic (1.1 per cent) glycine solution for irrigation, except one who used sterile water. No attempt will be made to correlate the results with the individual surgeon or with the instruments used.

The technique used was to obtain a preoperative serum glutamic oxalacetic transaminase level, usually on the day preceding surgery or early on the day of surgery and to repeat this test on the first three postoperative days. The only other factor studied was close clinical observation for symptoms similar to those of the original patient and for complications of surgery. No accurate estimate of bleeding was

Submitted March 15, 1961.

### *The Author*

● **Dr. Robinette, Dante, Virginia, former intern at Mercy Hospital, Springfield, Ohio, is now in general practice in Dante.**

undertaken, however it was not considered excessive in any of these patients. The entire group had an uncomplicated recovery except patient number 1 (see case report) and patient number 10, who died of other causes after having recovered from surgery.

The serum glutamic oxalacetic transaminase determinations were done colormetrically by the method of Reitman and Frankel.[3] By this method the normal range is 1 to 45 units with a mean activity of 16.4 (8.4) units. Using this method the standard deviation in our laboratory was 5.3 units. Ninety per cent of the tests were duplicated to the same concentration while the other 10 per cent varied by one meter reading.

## Results

Twenty-one patients, including the original patient (case report) were considered suitable for evaluation. The results from each of these will be found in Table 1. Table 2 summarizes the results and gives average results for all patients studied.

Of the 21 patients used, only three (14.3 per cent) failed to show any appreciable rise during the three postoperative test days. This leaves 18 (85.7 per cent) showing a definite rise. Of these 18 patients, 12 (66.7 per cent) had a rise to abnormal levels on one or more days. The greatest rise occurred most frequently on the first postoperative day and had usually returned to normal within the next 24 hours. The greatest single increase was 48 units with the average increase being 26 units.

The average age of patients was 66 years. Two of these patients (No. 1 and No. 14) had a final diagnosis of carcinoma of the prostate; the other 19 had only hyperplasia of the gland. One patient (number 9) was undergoing a secondary resection just a few weeks after the primary resection, when the values were obtained.

## Discussion and Conclusions

There are many factors that have not been mentioned which could possibly have influenced the reported results. Certainly, the standards of a rigidly controlled study have been somewhat compromised. Despite these omissions and the relatively small number of cases reported, we feel the results have been helpful in evaluating certain complications which may occur in these patients postoperatively. Perhaps the value of this work is that we have demonstrated a large number of these patients (57 per cent in our series) will have abnormally high transaminase with no other objective or subjective deviations from what

TABLE 2. *Summary of Results*

| | |
|---|---|
| Total number of patients | 21 |
| Number of patients showing postoperative rise | 18 (85% of total) |
| Number of patients showing no change | 3 (15% of total) |
| Number showing abnormal values (or 67% of patients showing postop. rise) | 12 (57% of total) |
| Highest level recorded | 102 Units |
| Greatest single increase | 48 Units |
| Average preoperative level | 22 Units |
| Average highest level for 12 patients with abnormal values postoperatively | 59 Units |
| Average increase all 21 patients | 23.9 Units |
| Average increase of 18 patients showing rise | 26 Units |
| Number showing greatest increase 1st day | 10 (55%) |
| Number showing greatest increase 2nd day | 6 (35%) |
| Number showing greatest increase 3rd day | 2 (12%) |
| Oldest patient | 85 Years |
| Youngest patient | 54 years |
| Average age of patients | 66 years |
| Number with complicating serious illness | 7 (33%) |
| Final diagnosis of benign hyperplasia | 19 (90%) |
| Final diagnosis of carcinoma of prostate | 2 (10%) |

TABLE 1. *Detailed Results*

| Patient Number | Age | SGOT Units Preop. | 1st | 2nd | 3rd | Greatest rise | Day of greatest rise | Associated Conditions |
|---|---|---|---|---|---|---|---|---|
| 1. | 65 | not done | 10 | 54 | 30 | 44 | 2 | Case report |
| 2. | 69 | 3 | 38 | 3 | 3 | 35 | 1 | None |
| 3. | 59 | 3 | 46 | 16 | 24 | 43 | 1 | None |
| 4. | 69 | 3 | 28 | 3 | 3 | 25 | 1 | None |
| 5. | 75 | 46 | 72 | 72 | not done | 26 | 1 | None |
| 6. | 78 | 30 | 24 | 22 | 46 | 16 | 3 | Chronic pulmonary emphysema |
| 7. | 68 | 24 | 46 | 30 | not done | 22 | 1 | Chronic bronchial asthma |
| 8. | 58 | 3 | 30 | not done | 3 | 27 | 1 | None |
| 9. | 67 | 10 | 24 | 54 | 10 | 44 | 2 | Rectus muscle hematoma |
| 10. | 85 | 30 | 3 | 34 | 16 | 4 | 2 | Multiple fractures and associated diseases |
| 11. | 72 | 24 | 30 | 16 | 3 | 6 | 1 | None |
| 12. | 69 | 3 | 3 | 3 | 3 | 0 | | None |
| 13. | 56 | 10 | 24 | 46 | 24 | 36 | 2 | None |
| 14. | 80 | 38 | 24 | 24 | 54 | 16 | 3 | None |
| 15. | 70 | 46 | 80 | 62 | 62 | 34 | 1 | Arteriosclerotic cadiovascular disease |
| 16. | 72 | 46 | 38 | 62 | 3 | 16 | 2 | None |
| 17. | 78 | 3 | 24 | 24 | not done | 21 | 1 | Diabetes mellitus |
| 18. | 54 | 38 | 30 | 38 | 30 | 0 | | None |
| 19. | 83 | 46 | 38 | 24 | 38 | 0 | | None |
| 20. | 79 | 3 | 16 | 46 | not done | 43 | 2 | None |
| 21. | 70 | 54 | 102 | 24 | 3 | 48 | 1 | Auricular fibrillation and nonspecific T-Wave changes |

is considered a normal postoperative recovery. Being aware that this may and does occur, we are better prepared to evaluate our laboratory findings in the problem patient who develops symptoms postoperatively.

We have not attempted to investigate the cause of these elevated transaminase levels. Suffice it to say, we consider the three most likely possibilities to be (1) hemolysis of red cells, (2) release of enzymes from the prostate, either transaminase as such or "lytic" enzymes resulting in release or activation of transaminase from other sources, or (3) a combination of these factors. Studies to determine the actual cause of this rise would appear to be indicated for full evaluation of the changes herein reported.

Other factors which may have influenced our study and also may warrant investigation in the future are: the technic and instruments used during surgery, coexisting disease states, the amount of tissue removed or left behind, the amount and duration of bleeding, the effect of any major surgical procedure on transaminase levels, the reliability of laboratory personnel performing the determinations, and the margin of error, or day to day reproducibility, of the method used for the determinations.

## Summary

This study of 21 patients undergoing transurethral resection of the prostate led to the following observations:

(1) Patients undergoing transurethral resection of the prostate may show asymptomatic elevations of serum glutamic oxalacetic transaminase levels. (2) More than 50 per cent of these elevations were above normal range. (3) This rise occurred on the first postoperative day and returned to normal by the second postoperative day.

Further study of these observations seems warranted.

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REDUCING DIETS. — Regardless of whether the greater part of the calories was from carbohydrate, protein, or fat, good loss of weight occurred in obese women on daily diets providing 800 calories. It therefore seems that, once the calorie intake has been decided and minimal nutritional requirements met, the composition of a reducing diet can be determined primarily by palatability and individual choice.

The six women who completed this cross-over study had moderate or severe simple obesity without evidence of endocrine or intracranial disease. Hospitalization seemed justified because of the degree of obesity in five patients (78 to 144 per cent above expected weight) and because of the earnest desire of one patient to lose weight (38 per cent above expected weight). During the entire study, these patients received vitamin supplements and an appetite-suppressant. For a preliminary period of 8 to 30 days, they received only the basic diet; they lost weight rapidly during this time, a total of 3.9 to 11.6 kg. The basic diet was made up of methylcellulose biscuits, "diabetic" fruit squash, lean beef or mutton, cheese or egg, cabbage, tomato, apple, and orange. It provided 507 calories per day from 29.9 Gm. protein, 25.6 Gm. fat, and 36.5 Gm. carbohydrate.

After the initial period described above, they were given the basic diet plus a supplement yielding about 300 calories a day — either protein, fat (butter), or carbohydrate (sugar). Each supplement was tested for 13 days by each patient, with the sequence being different for each patient and each test period being started with a day of near starvation. The total weight loss during the six weeks was significantly related to the weight at its beginning. Neither the composition of the diet nor the order of the test periods significantly affected weight loss. — *Abstract:* R. F. Fletcher, Marjorie Y. McCririck, and A. C. Crooke, Little Bromwich General Hospital, Birmingham, England: *British Journal of Nutrition,* 15:53-58 (No. 1) 1961.

# The Mortality and Morbidity of Myocardial Infarctions

## A Study of 75 Infarctions in 68 Patients

CLOYD L. DYE, JR., M.D.

THIS STUDY was conducted in an attempt to correlate the mortality and morbidity of patients with myocardial infarction with various factors including electrocardiogram changes, serum glutamic oxalacetic transaminase elevations, sex, age, presence of diabetes, and anticoagulant therapy. Also, an analysis of the complications that occurred and the time at which they occurred were noted.

### Material and Methods

Sixty-eight charts, picked at random from the records of Mercy Hospital, Springfield, Ohio, were studied. These charts were selected by the Medical Record Librarian starting with the year 1955. All charts coded as acute myocardial infarction secondary to coronary thrombosis were inspected until a total of 68 acceptable charts were reviewed. A case was considered acceptable as representing myocardial infarction if one or a combination of the following existed: (1) An elevation of serum glutamic oxalacetic transaminase greater than 50. (2) Electrocardiogram changes considered diagnostic of infarction. (3) Autopsy findings of acute coronary occlusion. (4) Clinical picture of infarction plus any one of the above three factors.

It is interesting to note that all of the patients in this series had a clinical picture of myocardial infarction except one patient. A total of 68 patients were studied with a total of 75 infarctions; seven patients had two infarctions and each infarction was studied separately.

### Findings

There were 73.2 per cent male patients and 26.8 per cent female patients. The overall mortality in the 68 patients with 75 infarctions was 29 per cent, (22 deaths). The mortality rate in the female group was 50 per cent. The average age of the women in the series was 65 years; the youngest was 50. Fifteen per cent of the men were under the age of 50; the youngest was 42. Seventy-seven per cent of the deaths occurred within the first 48 hours following infarction; 15 per cent of the 68 patients were diabetics and the mortality rate in this group was 30 per cent.

Attempts to correlate mortality with the degree of elevation of the serum glutamic oxalacetic transaminase (SGOT) was difficult since the majority of the patients who died, did so soon after infarction. Thus in most of these patients a SGOT was either not obtained or obtained prior to any appreciable tissue necrosis. In 10 of the 22 patients the SGOT was less than 45 units. In the remaining eight patients the average SGOT was 195 with a range of 124 to 320. Only three of the foregoing 14 patients who had no SGOT determination performed, or failed to have an elevated SGOT, were not autopsied. These three patients died in the first 24 hours and the diagnosis was made on the basis of the electrocardiogram and clinical picture.

The electrocardiogram (EKG) changes were divided into major (pathologic Q-waves or Q-S complex), minor (S-T segment elevation and/or T-wave inversion), and no change.[1] Of the 22 patients who died, 23 per cent had major changes, 32 per cent minor changes, and in two patients there was no change on EKG; in one patient there was no S-T segment, T-wave or QRS change, but there was bigeminal rhythm with premature ventricular systoles.. In six patients no EKG was obtained because of the rapidity of death. In one patient there was an associated left bundle branch block.

Of the three patients with no QRS, S-T segment or T-wave changes on electrocardiogram (EKG), two were autopsied and had evidence of acute myocardial infarction. These patients died within 48 hours after

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### *The Author*

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infarction. In one the location of acute thrombosis was in the circumflex branch of the left coronary artery, and the other patient had an acute thrombus formation in the anterior descending branch of the left coronary. The third patient who died without evidence of recent infarction on EKG but without autopsy being performed did show EKG changes of an old posterior infarction. This patient had a serum transaminase elevated to 130 units. He died the sixteenth day. The six patients without an EKG done were all autopsied and showed evidence of acute infarction. Of the patients who survived 60 per cent had major and 40 per cent minor and/or a major change on EKG.

There were 36 incidences of complications in 25 of the 75 infarctions. Some of the patients had more than one complication; 82 per cent of the complications occurred within the first four days following infarction. The latest date at which a complication occurred was the twenty-third day. The various complications and their incidence are listed in Table 1.

TABLE 1. *Various Complications and Their Incidence.*

| Complication | Per Cent of Total Complications | No. of Patients with this Complication | No. of Deaths |
|---|---|---|---|
| Shock | 30% | 12 | 8 |
| Arrhythmias | 28% | 10 | 3 |
| Congestive Heart Failure | 14% | 5 | 3 |
| Pericarditis | 8% | 3 | 2 |
| Embolism | 6% | 2 | 0 |
| Extension or new infarction | 6% | 2 | 1 |
| Ruptured myocardium | 3% | 1 | 1 |
| Hypoprothrombinemia (Drug induced) | 3% | 1 | 1 |

Of the patients who died 18 per cent had anticoagulant therapy; of those that lived 78 per cent had anticoagulant therapy. Of the total group 53.3 per cent had anticoagulant therapy. Forty-four per cent of the patients with complications were on anticoagulant therapy. Eleven of the 25 with complications died, and only two of that 11 (18 per cent) were receiving anticoagulants. However, it is of interest to note the small percentage of patients that received effective levels of anticoagulant treatment—effective levels are here defined as a prothrombin time at least twice the control.[2] The patients maintained at such levels for at least two thirds of their hospital stay were considered to have received adequate anticoagulant therapy; of the 18 per cent (four patients) that died on anticoagulant treatment, two were undertreated, one died as a result of hemorrhage from drug induced hypoprothrombinemia, and the other patient died in the first 24 hours after receiving 200 mg. Depo®-Heparin intramuscularly.

Of the 78 per cent on anticoagulant therapy who survived (36 patients), only six received adequate treatment. The remaining 30 patients failed to have their prothrombin times maintained at greater than twice the controls for two thirds of their hospital stay.

## Conclusions

The age of the female patients with infarction was greater than the male patients. All the female patients in this series were postmenopausal. It was noted that 13 per cent of the men were under age 50, whereas there were no women under 50. Also the mortality rate in the women was greater (50 per cent) than the overall mortality rate (29 per cent). Thus this disease, one would conclude from this series, is one predominantly of men (73.2 per cent) and postmenopausal women with a much better prognosis for the man. A study recently reported by Robinson, Higano, and Cohen[3] reveals an increased incidence of coronary artery disease in women who have been castrated prior to the menopause.

The mortality rate in the diabetic patients proved to be no greater than in the entire group. The majority of deaths (77 per cent) occurred in the first 48 hours following infarction; thus, any patient in this series that lived past the first 48 hours had a relatively good prognosis.

White, Bland and Levine[4] reported in a recent study on the prognosis of myocardial infarction they found a steadily decreasing mortality in the first three months. However, some of these patients were not seen until days after the onset of infarction. It was noted in their group of 200 patients that the most important clue favoring longevity and return to a normal program of life was the degree of completeness of recovery after the first month of convalescence.

Gubner and Ungerleider[5] report an increased mortality rate six to seven times that of the average population of the same age groups for two years following acute myocardial infarction. Thereafter they found the mortality rate fell progressively with increased intervals of time. Three of five patients in this series surviving the acute attack, lived longer than five years.

It was difficult to correlate serum glutamic oxalacetic transaminase (SGOT) elevations with mortality and then ascribe a prognostic value, as most of the patients who died did so soon after infarction. Thus many of these patients either had only one SGOT soon after infarction before there was any appreciable necrosis or no test was obtained due to the patient's sudden death. In the eight patients with elevated SGOT who died, the average elevation was 195 units with a range of 124 to 320 units. In the surviving patients the average SGOT was 139 units with a range of 50 to 320 units.

Ladue[6] reports an elevation greater than 350 units as indicative of a poor prognosis. He states that one can correlate the extent of necrosis seen at the autopsy table with the degree of elevation and the duration of the elevated serum glutamic oxalacetic transaminase.

Electrocardiographic changes were present in all patients who lived and in all patients who died after

the first 48 hours except for one patient. In this series of 75 infarctions the electrocardiogram showed evidence of infarction in all patients who lived longer than 48 hours after onset of infarction.

Shock was the most frequently noted complication. Arrhythmias were the second most common complication. Congestive heart failure occurred in five patients. In two of these it was of minor clinical significance and was noted as rales in the bases on physical examination; the other three patients died, two of them within the first 24 hours. Only one patient developed congestive heart failure late (on the fourteenth day), and he died suddenly on the twenty-third day. No autopsy was obtained.

Pericarditis was noted in 3 of the 75 infarctions. One patient died within the first 24 hours. Another patient developed a friction rub on the fourteenth day and died suddenly on the twenty-third day. The third patient had no clinical implication associated with the friction rub. Anticoagulant therapy was not used in these patients.

There were two embolic episodes, one was cerebral and the other pulmonary, and both survived. The cerebral insult occurred on the twentieth day and the pulmonary embolism on the fourth day.

Two patients showed evidence of re-infarction or extension of the original area of infarction. Autopsy revealed one patient had a ruptured myocardium, death occurring on the second day. One patient died on the fifth day from gastrointestinal tract hemorrhage associated with drug induced hypoprothrombinemia.

The value of anticoagulant therapy is difficult to evaluate for most of the patients not receiving anticoagulant therapy died before treatment could be instituted. Also, there is no adequate control group for comparison. It might appear rather impressive that 78 per cent of surviving patients received anticoagulant therapy, whereas only 18 per cent of those who died received anticoagulants. This 78 per cent is less impressive, however, when one recalls that only 17 per cent (6 out of 36) were receiving effective dosages of anticoagulants to maintain prothrombin time two times control.

## Summary

Sixty-eight patients with 75 infarctions were studied correlating mortality and morbidity with various factors and noting the complications. The patients were predominantly men and the majority of women were postmenopausal. The mortality rate was much higher in the women. The majority of deaths occurred in the first 48 hours.

Serum glutamic oxalacetic transaminase elevations were found difficult to evaluate since the majority of deaths occurred before there was any appreciable necrosis.

There were electrocardiogram changes considered diagnostic of acute myocardial infarction in all patients who survived more than 48 hours, except in one patient.

One third of the patients experienced some complication, the majority occurring within the first four days. The three most frequent complications were shock, arrhythmias, and congestive heart failure.

The merits of anticoagulant therapy could not be evaluated from this study because of the lack of an adequate control group.

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CHLOROTHIAZIDE IN HYPERTENSIVE PATIENTS. — Cardiac output was determined in compensated hypertensive patients. Five were studied by the direct Fick method, and two by the dye-dilution technic before and after chlorothiazide therapy. There was a reduction of cardiac output, mean arterial pressure, plasma and blood volumes, body weight and pressures in the right atrium. The total peripheral resistance was increased.

These data add support to the suggested mechanisms of the antihypertensive effect of chlorothiazide — namely, that contraction of plasma volume and possibly reduction of tissue pressure lead to a decrease in filling pressure in the right side of the heart and hence to a decreased cardiac output. — Edward D. Frohlich, M. D., Washington, D. C., et al.: *The New England Journal of Medicine,* 262:1261, June 23, 1960.

# Prolonged Coma from Doriden®

## Case Report

JAMES L. FISHER, M. D., RAYMOND HALL, M. D., DAVID BELINKY, M. D.,
and MICHAEL A. KACHMER, M. D.

GLUTETHAMIDE (Doriden® Ciba) is an oral nonbarbiturate sedative. Used as a nighttime soporific in dosage of .25 Gm. to .5 Gm., it does in most cases produce smooth, rapid onset of sound sleep lasting four to eight hours, followed by clear awakening without hangover. It is generally considered to be one of the milder hypnotics of medium duration ranging between secobarbital and Sodium Amytal.®

Doriden has not so far been known as a dangerous drug in overdosage although the packaging literature describes the symptoms and treatment. Records of the Youngstown Hospital show only two patients to date, both of whom recovered. In the case described here, approximately 30 tablets of .5 Gm. each were taken with suicidal intent. The attempt was nearly successful.

### Case Report

The patient was a woman of 51 years, divorced, and suffering from a depressive state for which treatment with shock therapy had been given in the past year. On April 12, 1961, she was found unconscious in her bed and an empty bottle of Doriden was found in her room. She was admitted at 4:30 p. m. to the emergency department of the Youngstown Hospital.

Examination showed an obese, middle-aged woman in coma. There was no response, no resisting movement, no gag reflex. The eyes were rolling, pupillary reflexes were sluggish and respiration was shallow. Blood pressure was 170/90. Pulse rate 100 per minute. Color was florid and the skin was dry.

A stomach tube was put down and 60 cc. of universal antidote administered. Gastric lavage returned much flaky material and was continued until the return was clear. Phospho-soda 60 cc. was instilled and the tube withdrawn. An airway was inserted in the trachea and oxygen was administered by mask. A retention catheter was installed.

Urinalysis showed no albumin or sugar. An intravenous infusion of 5 per cent glucose in water was started and 2.0 cc. of Metrazol® was injected in the tubing. This produced some muscular response which was temporary. Metrazol 2.0 cc. was injected in the bottle by error so it was allowed to run and no more injected in the tubing.

On April 13 her condition had deteriorated. There were scattered rales and rhonchi in the lungs and much mucus in the throat. The urine showed albumin 2 plus with a few red blood cells and many hyaline casts. Blood chemistry showed a normal blood sugar (in spite of the intravenous glucose) normal blood urea nitrogen and $CO_2$ combining power. By this time her few accessible veins were obliterated and a cut down was done at the ankle. Polyethylene tubing was inserted for continuous intravenous infusion. The foot of the bed was elevated, the position was changed frequently and suction was used constantly to clear the pharynx. Tetracycline-V was given intramuscularly, 250 mg. every six hours. Caffeine Sodium Benzoate 7.5 gr. was added to each bottle of glucose solution.

Submitted May 31, 1961.

### *The Authors*

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● Dr. Hall, Youngstown, is chief of Otolaryngology, Youngstown Hospital.

● Dr. Belinky, Youngstown, coroner of Mahoning County, is a member of the consulting staff, Youngstown Hospital Association.

● Dr. Kachmer, Youngstown, is head of the Department of Psychiatry, St. Elizabeth Hospital.

On April 14 the patient was in extremis. Respiration was labored, cyanosis was marked and the lungs were filled with bubbling rales. Apparently no air was coming through the airway. She was taken to surgery where the tracheal tube was removed and a fresh one inserted. The work by the nurses in suctioning the pharynx and maintaining the fluid intake was heroic. Dr. Belinky (Mahoning County Coroner) saw her in consultation and ordered more intravenous stimulation.

In the early morning hours of April 15 the patient began to cough and make incoordinated movements. By noon she was awake and seemed aware of her surroundings. She was in evident discomfort from the tracheal airway and as soon as it appeared safe to do so it was removed. Intravenous medication was continued.

By April 16 she was taking fluids by mouth and responding to questions. Her voice was hoarse and she complained of sore threat. Intravenous tubing and indwelling catheter were removed but the antibiotic was continued. There were crepitant rales in both bases.

On April 18 she was up and about and taking a soft diet. She admitted taking 30 tablets of Doriden at 1:30 p. m. on April 12th because she could not cope with the problem of filling out her income tax return. She was transferred to the psychiatric ward at St. Elizabeth's Hospital, service of Dr. Kachmer for treatment of the underlying depression.

She was given six electroshock treatments at St. Elizabeth's Hospital to which she responded favorably and was discharged May 11, 1961, in good condition.

Comment: After taking 15.0 grams of Doriden this patient was unconscious for 70 hours in spite of all efforts to remove the drug and administer stimulation. Extracorporeal dialysis, in process of installation, was not available at the time. It is recommended that no patient be given more than a week's supply of any hypnotic (7 tablets) on one prescription. Dr. Kachmer has seen two cases of generalized convulsions on withdrawal of Doriden in patients who had taken large doses over a long period.

# Unusual Aortic Injuries

EDWARD P. PASSARO JR., M.D., and WILLIAM G. PACE, M.D.

MODERN surgical techniques make possible the repair of injuries to the aorta. The deterrent to increased survival after aortic injury remains the failure or delay in diagnosis. Although high speed trauma with multiple severe injury usually alerts the physician to the possibility of injury to the aorta, the injury which appears to be only superficial or bizarre may also be responsible for an aortic laceration. In the present series of 20 cases of aortic laceration, six patients with unusual or minor trauma are reported in detail to illustrate the need for close observation in this group of patients.

A review of autopsies at The Ohio State University from 1947 to 1958 shows 20 cases of aortic injury. Fifteen of the 20 were dead on arrival. Of the remaining five, two died within one hour of admission, and the remaining three patients all survived beyond 24 hours. The cause of death was exsanguination in 11. Blood was reported in the thoracic cavity in 15 patients. In nine of these the amount exceeded 1500 cubic centimeters.

The most common associated injury was that of the thoracic cage. There were 12 patients with rib fractures, one with fracture of the sternum, and four with fractures of the thoracic vertebrae. In no case was there pleural puncture. Eight patients sustained fractures of the extremities and eight more had injury to an abdominal viscus. Five patients had an associated skull fracture.

The aortic laceration was transverse in all but two instances, one of these was punctate, and the other was "V" shaped. Eleven lacerations were over 2 cm. in length (Fig. 1). Three patients had more than one laceration (Fig. 2). The aortic laceration was found on the anterior aspect of the descending thoracic aorta in nine cases, on the anterior ascending aorta in four cases (Fig. 3), and on the anterior arch in four cases. The abdominal aorta was the only site of laceration in two patients.

## Case Reports

Case 1. A 32 year old harness driver was involved in a racing accident. He was dead on arrival in the emergency room. There was no external evidence of severe injury. On postmortem examination there were several rib fractures but no other associated injuries. There was 2,500 cc. of blood in the left hemithorax. There was a complete transection of the descending aorta with a 1 to 2 cm. separation of the severed ends. The abdominal viscera were uninjured.

Case 2. An 18 year old white man, who had been working atop a 126 foot silo, was found dead at the base of the silo at 1:00 a.m. His fall was not observed. At autopsy, a right Colles' fracture and rupture of the bladder were noted. There were no marks of external thoracic injury despite the presence of a completely transected aorta immediately below the left subclavian artery.

Case 3. A 69 year old white man apparently had a "fainting spell" while working in his garden. Several days later, while he was painting, he fell from a stepladder. He was thought to have had a myocardial infarction just prior to his fall. Autopsy examination did show occlusion of the right coronary artery by an atheromatous plaque. In addition, a "V" shaped laceration 3 mm. long was noted 6 mm. above the aortic valve ring. There was less than 500 cc. of blood in the pleural space. A skull fracture was also present. The low blood loss seemed to indicate that the patient died as a result of his coronary artery disease rather than from his aortic laceration.

Case 4. A 200 pound, 30 year old man was literally blown through the roof of a wooden building by an explosion. He sustained fractures of his ribs, both arms, and right leg and a laceration of his spleen. He arrived in the



FIG. 1. *Complete transection of the aorta. The hematoma that forms may act to prevent immediate exsanguination.*

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Submitted March 30, 1961.

## *The Authors*

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hospital in severe shock but with vigorous blood replacement his blood pressure rose to 130 mm. of mercury systolic and remained at adequate levels thereafter. There was a progressive rise in his temperature, and he died at the end of 30 hours of hospitalization. Along with the other injuries, there was a 1.0 cm., incomplete transverse laceration of the anterior aorta immediately below the ligamentum arteriosum noted at necropsy. The cause of death was cerebral hemorrhage.

**Case 5.** A 64 year old man was diagnosed as having generalized arteriosclerosis four years prior to this admission. In the interim he had no specific complaint and was not hypertensive. On the day of admission, he fell down a flight of stairs at home and lost consciousness. He was rushed to the emergency room where his blood pressure was not obtainable. A venesection was performed but the patient died within minutes of his arrival. At necropsy a skull fracture with herniation of a small portion of the brain was noted. Immediately distal to the subclavian artery there was a 0.5 to 1.0 cm. transverse laceration of the aorta.

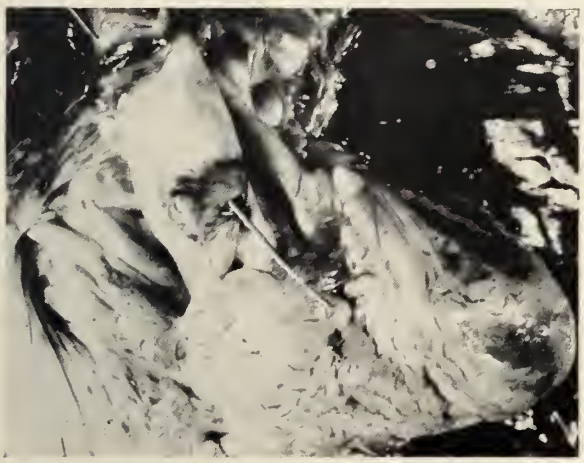


FIG. 2. *Multiple lacerations. A probe has been passed obliquely through two lacerations.*



FIG. 3. *Complete transection of the ascending aorta.*

**Case 6.** A 70 year old woman was eating a pork chop when she experienced a sharp pain in the midline of the lower third of the chest. This pain continued for the next two days and attempts to drink fluids were followed by prompt regurgitation. She improved over the next two days and was able to retain fluids. She then became slightly dyspneic with a nonproductive cough. The following day she had emesis of small quantities of a brown fluid interpreted by her as "cough medicine." Shortly thereafter her emesis contained clots of bright red blood, and she was admitted to the hospital. Her temperature increased to 105°F., and, on the following day after drinking a glass of water, she regurgitated approximately 2 liters of bright red blood and died.

At autopsy a bone spicule 4 cm. in length and 3 mm. in diameter was found buried in the esophageal wall. It connected via a fistulous tract to a 4 mm. punctate laceration of the adjoining descending thoracic aorta. Suppurative mediastinitis (Fig. 4) was also found.

## Discussion

Automobile accidents are the major cause of injury to the aorta. With the increasing number of vehicles and their greater speeds, it can be assumed that there will be more of these injuries. Surprisingly, however, one third of the aortic lacerations in our group resulted from seemingly minor or bizarre accidents. This supports the thesis that little or no correlation



FIG. 4. *Autopsy specimen from Case 6. The white marker indicates the track of the bone spicule.*

can be drawn between the apparent degree of external injury or force experienced and the type of internal injury noted. The mechanics by which aortic lacerations are produced has been the subject of numerous ingenious experiments in the recent past. The major force probably results from the inertia of a column of blood acting upon the points of fixation of the thoracic aorta. These points are the attachment of the aorta to the pericardium and the ligamentum arteriosum. Over 80 per cent of aortic lesions are located about these two points.

Patients who are found to have lacerations of the aorta may present with severe associated injuries. These injuries often demand prompt if not heroic measures. As a consequence, an intrathoracic catastrophe may go unnoticed or unsuspected. The physician confronted with the severely injured accident victim should maintain a high index of suspicion of possible intrathoracic injury. He must carry out an adequate examination. A review of all cases of hemothorax at The University Hospital indicated that one-third were undiagnosed or unsuspected when the patient was first examined.

It should be pointed out that intrathoracic bleeding is usually a silent and insidious process. The usual supine anterior posterior chest roentgenogram is not adequate to detect the presence of hemothorax. An upright roentgenogram of the chest is mandatory. With proper care this can be accomplished in practically every patient. A program of serial x-rays of the chest should be planned when the patient is first seen. Evidence of a widening mediastinum or intrathoracic collection of fluid should be carefully sought. Repair of a laceration of the aorta can be successfully accomplished with present advances in surgery. The need is for an awareness of this problem among physicians and a more aggressive approach by surgeons.

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## Franklin County Pelvic Cancer Delay Committee Report

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee at its November 15, 1961 meeting.

**Case Number 97:** This 39 year old white woman, gravida XIII, Para IX, abortus IV, was admitted in early labor to the hospital in a small Ohio town. She did not have the benefit of any prenatal care and considered vaginal spotting of no significance. When first seen by a physician in the labor room, examination revealed a large cervical lesion and specimen was taken for biopsy. A presumptive diagnosis of cervical carcinoma was made and the patient was therefore subjected to a cesarean section. Her postoperative course was uneventful and she was discharged home on the seventh postoperative day. Prior to her discharge, the Pathology report of the cervical biopsy was squamous cell carcinoma of the cervix and plans were made for definitive irradiation therapy.

After the patient's discharge, several attempts were made to bring her to the irradiation therapeutist but she failed to keep her appointments. After five months of post-cesarean-section intermittent bleeding she reported to the Gynecology Tumor Clinic at Ohio State University Hospital for irradiation therapy. The patient was admitted to the hospital on November 13 at which time pelvic examination revealed a clinical stage 3 carcinoma of the cervix and she received central Cobalt 60 therapy, 3000 roentgens to point A and 5000 roentgens tumor dose by rotating Cobalt teletherapy.

### Comments

A clinical stage 3 carcinoma of the cervix complicated by the last trimester of pregnancy, even when diagnosed without the element of a delay factor and inadequate therapy, carries a poor prognosis. This case probably represents a patient delay of approximately six months postoperatively and six months preoperatively. This cervical lesion would have been detectible by examination during the first trimester of pregnancy or by a Papanicolaou smear at the same time.

These two diagnostic procedures are indispensable and all prenatal patients should have the benefit of them. Biopsy of specimen from suspicious cervical lesions should be done in the office and, when necessary, supplemented by a cold knife conization in the hospital. The latter is extremely important if the cervix appears normal and a suspicious or positive Papanicolaou smear is obtained. When confronted with cervical carcinoma in early labor, delivery by cesarean section becomes mandatory followed by complex external and then central irraditation therapy. Delivery through the vaginal route would surely disseminate carcinoma cells and in all probability result in cervical lacerations and cervical dystocia.

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PREVENTION OF THROMBI. — The propagation of a relatively standard degree of venous thrombosis in dogs was prevented by heparin if the Lee and White clotting time was kept elevated above 1.5 times the pre-heparin value. Neither bishydroxycoumarin (Dicumarol®) nor ethyl biscoumacetate (Tromexan®) prevented thrombus propagation unless prothrombin values were dangerously depressed (well below 20 per cent). The authors believe that heparin and coumarin derivatives should be reappraised as therapeutic agents in venous thrombosis. — (ABSTRACT): Larry C. Carey, M. D., and Roger D. Williams, M. D., Columbus: Comparative Effects of Dicumarol, Tromexan, and Heparin on Thrombus Propagation. *Annals of Surgery,* 152:919-922 (November) 1960.

# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

HORACE B. DAVIDSON, M. D., *President*

PRESENTATION OF CASE

FIRST ADMISSION: A 62 year old white man was admitted to Ohio State University Hospital because of swelling of his feet and ankles of one year's duration. For approximately one year he had had pain in the left hip which became worse on ambulation; four months prior to admission he was found to have diabetes, which was controlled by dietary measures. He gave a history of chronic cough occasionally productive of sputum. He denied orthopnea, paroxysmal nocturnal dyspnea, chest pain or other symptoms. His past history was not remarkable.

His physical examination showed a thin, chronically ill white man with a blood pressure of 174/94, a regular pulse rate of 72 per minute and respiratory rate of 18 per minute. His skin was dark, but the patient stated that it had always been so. There were expiratory wheezes in both lung fields. A firm, smooth, nontender liver was felt 6 fingerbreadths below the right costal margin; there was no splenomegaly. The feet and ankles showed 3 plus pitting edema.

His hemoglobin was 15.6 Gm./100 ml.; the red blood cell count was 5.43 million, the white blood cell count 10,400 with a normal differential count. The urine was normal. The blood urea nitrogen was 15 mg./100 ml.; the serum albumin was 3.4 Gm., the globulin 3.4 Gm./100 ml.; alkaline phosphatase was 7.9 units; cholesterol was 210 mg./100 ml. with 71 per cent esters. A bromsulphalein test showed 8 per cent retention of the dye after 45 minutes. The serum iron was 99 mcg. with a total iron-binding capacity of 99 mcg./100 ml. Fasting blood sugars ranged between 200 and 300 mg./100 ml. Chest x-rays showed questionable left ventricular enlargement. X-ray of the left hip showed degenerative arthritis.

The patient was afebrile throughout admission. His edema was felt to be on the basis of associated liver disease and with mercurial diuresis he lost 9 lbs. in weight. Orinase® was prescribed for the treatment of his diabetes. Skin biopsy and needle biopsy of the liver were done; both were tolerated well. By phlebotomy 1500 cc. of blood were removed with reduction of the hemolobin to 10.6 Gm. prior to discharge. He was discharged on a diabetic diet and Orinase, 1 Gm. twice a day.

Submitted November 30, 1961.

*Presented by*

- Robert L. Wall, M. D., Columbus, and
- Emmerich von Haam, M. D., Columbus.

Edited by Dr. von Haam.

### Second Admission

The patient was readmitted 10 months later because of persistent left hip pain. He had been followed in clinic, where four 500 cc. phlebotomies had been done since his first hospitalization. Because his blood sugars ranged between 250 and 350 mg. with low urine sugars, NPH insulin, 15 units a day, had been started in clinic. His cough had become worse and was now productive of up to a half cup of foul green sputum a day. The physical findings were not markedly changed.

There were rales and rhonchi in the right lower lobe, and the spleen was felt 2 fingerbreadths below the left costal margin. The patient's hemoglobin ranged between 9.8 and 12.8 Gm.; the red blood cell count showed a macrocytic hyperchromic type of anemia; the white blood cell count was 11,700 with normal differential count. Urinalysis showed 3 plus sugar, 5 mg. of protein, and 3 to 8 white blood cells. The bromsulphalein test showed 6 per cent retention of the dye after 45 minutes. His serum iron was 52 mcg. with an iron-binding capacity of 100 mcg./100 ml. Sputum culture grew an *alpha Streptococcus, H. influenzae* and *Klebsiella.* A gastric analysis showed no free acid with caffeine stimulation; a Shilling test showed 10 per cent excretion of the cobalt in 24 hours. Bronchograms showed chronic bronchitis and bronchiectasis of the right lower lobe. The patient had temperature elevations up to 101°F. on the second through eighth hospital days which was felt to be due to a right lower lobe pneumonia; he was treated with Terramycin® with good response. His diabetes was well controlled with diet and 15 daily units of

NPH insulin. A 500 cc. phlebotomy was done prior to his discharge on the eleventh hospital day.

### Third Admission

He was admitted three years later for evaluation of his loss of appetite and nausea. In the interim he had been followed in clinic. His insulin requirements had risen to 40 units of NPH insulin a day. In the first two years he had approximately 35 phlebotomies. At the end of this time his hemoglobin had dropped to 6.5 Gm. One month prior to his third admission he had developed progressive weakness, poor appetite, nausea and occasional vomiting. Physical examination showed a very thin white man. There were coarse rhonchi and wheezes bilaterally in the lungs. A hard, smooth, nontender liver was felt 6 fingerbreadths below the right costal margin. The hemoglobin was 10.1 Gm., the red blood cell count 4.31 million, the white blood cell count 9,700 with a normal differential count. Bromsulphalein test showed 20 per cent retention of the dye after 45 minutes. Serum iron was 21 mcg. with a total iron-binding capacity of 350 mcg./100 ml. An upper gastrointestinal x-ray series showed no abnormalities. The patient was discharged after three days.

### Final Admission

One month after leaving the hospital the patient was again admitted. Several days after his discharge he began to notice increasing abdominal swelling, increasing orthopnea and dyspnea, and he also began to complain of some intermittent right upper quadrant and upper abdominal pain. In the last two weeks on occasion he had noted light stools and dark urine. His physical examination revealed a debilitated white man. There were expiratory wheezes in both lung fields. The abdomen was moderately distended and a fluid wave was present. The liver could be felt 6 fingerbreadths below the right costal margin and was firm, smooth and nontender. His hemoglobin was 9.5 Gm., the white blood count 11,600 with a normal differential count. The fasting blood sugar was 172 mg. The bromsulphalein test showed a 39 per cent retention after 45 minutes. The prothrombin time was 74 per cent. Serum iron was 29 mcg. with a total iron-binding capacity of 276 mcg./100 ml.

Throughout hospitalization the patient complained of fullness in the abdomen and moderate to severe pain in the upper abdomen, especially after meals, for which he sometimes required narcotics for relief. He was given Mercuhydrin,® which failed to promote diuresis. His diabetes was controlled by diet and 40 units of NPH insulin per day. Two thousand cubic centimeters of cloudy yellow fluid were removed from his abdomen, and a smear of the fluid contained cells of Papanicolaou Class III. A bacterial culture showed no growth.

A second paracentesis of 2500 cc. of clear yellow fluid was done later. Following the paracenteses he experienced some relief from the fullness but continued to have his episodes of upper abdominal pain. A needle biopsy of the liver was done on the twelfth hospital day, which he appeared to tolerate well. He became more lethargic and his food and fluid intake diminished; however he did not become unresponsive at any time. On the evening of the nineteenth hospital day he passed a large tarry stool, became apneic, and despite attempts at resuscitation died a half hour later.

## CLINICAL DISCUSSION

DR. WALL: This man had four admissions to the hospital over a period of more than four years. Starting at the age of 61 he developed some arthritis in his left hip which proved to be some type of degenerative arthritis radiologically and which did not enter his subsequent clinical picture too much. At this time he was also found to be a mild diabetic. The diabetes became worse with time. It was at first unsuccessfully treated with Orinase and later on required insulin. He also had a chronic cough for which an explanation was found during one of his later admissions. He was also mildly hypertensive initially, but this did not influence the progress of his illness. He had a dark skin which he stated he had had all his life, and this I would rather doubt in the face of other evidence. At least I would suspect that it was getting darker, but I think this is something a patient would have difficulty in appreciating in a chronic disease such as this man may have. Also he had an enlarged liver and bilateral ankle edema.

His first laboratory studies showed a bromsulphalein excretion test of 8 per cent, which would seem to be important in view of subsequent observations. His serum iron is extremely interesting since he was completely saturated, his iron-binding capacity not exceeding his actual serum iron. I cannot recall ever seeing a patient who had 100 per cent saturation of his iron-binding capacity. Another thing is that his serum iron was not elevated. I think this is extremely important unless it is related to the fact that this man had some infectious process at the time we first saw him. He did not seem to have any hematologic abnormality at that time and his red blood cell count and hemoglobin serve as excellent reference points for subsequent observations. They did a liver biopsy the result of which was obviously withheld from the protocol for reasons we all understand. Then they give the diagnosis away a little bit, because they started taking blood off him and took 3 pints off in rather rapid succession until he was anemic prior to discharge.

### Hemochromatosis Suspected

This, as we all would recognize, suggests that this man was thought to have hemochromatosis, which diagnosis was suspected by the skin pigmentation, liver cirrhosis, and diabetes and possibly was verified by the liver biopsy in the face of confusing serum iron observations. He was treated with Orinase, and we now know that if he had cirrhosis and diabetes Orinase

would not be expected to work too well. This was proven at his second admission, and he was switched to insulin. He was admitted this time because of progression of his pulmonary symptoms with the production of large quantities of foul green sputum. Now his spleen was enlarged and his hemoglobin varied between 9 and 12 grams.

He had only had four authenticated phlebotomies in 11 months, which is hardly a very vigorous approach to the treatment of hemochromatosis. To treat a hemochromatosis patient you really ought to bleed him once a week to keep him iron-hungry and mobilize his iron. But despite this rather suboptimal treatment his hepatic function over that year had not gotten any worse.

### Bronchiectasis and Macrocytic Anemia

His chest problem seemed to be predominant at that time, and he was discovered to have bronchiectasis of his right lower lobe on the basis of a bronchogram. He was treated for this, and interestingly enough, at this time he developed a macrocytic, hyperchromic anemia. This is not at all uncommon in people with very severe hemochromatosis who have not been treated by phlebotomy, as they develop a folic acid deficiency consequent to their hepatic insufficiency. Would he actually have had less macrocytic anemia if he had been more vigorously phlebotomized during the last year? I don't know, but with the onset of his macrocytic anemia it became very difficult to pursue a vigorous phlebotomy program. This is unfortunately what you will encounter in some patients who are diagnosed late because hemochromatosis has not been thought of in the diagnosis. He had a normal Shilling test at this time, and the gastric analysis showed no free acid on caffeine stimulation.

### Now Iron-Deficient

Three years later he was readmitted with weakness, anorexia, and occasional vomiting and nausea. During this interval he had been treated quite vigorously and his hemoglobin had dropped to 6.5 Gm., which stopped any further phlebotomies. On admission he had recovered from this vigorous treatment and had a 10 Gm. hemoglobin. Now his serum iron was only 21 mcg. and the iron-binding capacity was 350 mcg./100 ml. If correct, this would mean that this man was now iron-deficient and had an increase in his iron-binding capacity. It is difficult to understand how he could generate that much beta 1 iron-binding protein in the face of a failing liver. His liver was worse, as proven by his BSP test.

His final admission, which was less than a month later and terminated in his death, was caused by ascites, dyspnea, abdominal pain, and the intermittent appearance of light stools and dark urine — focusing more and more attention on his liver. He had expiratory wheezes in his right lung field suggestive of emphysema in addition to his bronchiectasis, which was not amenable to corrective surgery. He was again anemic, had a marked retention of brome dye, and the serum iron again was very low.

### Hepatocarcinoma and Hepatic Coma

On examination of his ascitic fluid suspicious cells were found. Everybody has been fooled by those cells in pleural and abdominal effusions, but if a man with hemochromatosis and failing liver function has them, I think it would be foolish not to think of a primary hepatoma, because this is such a common occurrence in patients with hemochromatosis who are unresponsive to phlebotomy therapy. He had another needle biopsy done on his twelfth hospital day, the results of which were not revealed. At this time hepatic coma seemed to threaten. He had a massive tarry stool, became apneic, and died shortly. We wonder possibly whether he might have been oozing into his stools for some days, thus contributing to his hepatic insufficiency. I think we can suspect that he might have had esophageal varices with his progressive hepatic disease and that he might have bled from them even though there was no hematemesis but only tarry stools, or that he might have bled from stomach ulcers, which are about as common a source of upper gastrointestinal bleeding in cirrhosis regardless of the etiology of the cirrhosis.

So I would summarize my clinical impression that this man had hemochromatosis with liver cirrhosis, diabetes mellitus and skin pigmentation. We know that the skin pigmentation consists mostly of melanin. As the disease progresses it also incorporates iron into the skin. We would believe that because of progression of his hepatic failure, as well as of his anemia, he probably had a primary carcinoma of the liver. I would believe that his terminal episode was probably from esophageal varices or gastric varices with superficial ulceration, and I would believe that as incidental diseases he had emphysema, unilateral bronchiectasis, and degenerative arthritis of his hip.

In the differential diagnosis I don't think you can stray very far from the diagnosis of hemochromatosis, and the only exotic thing that can simulate this condition is Kaschin-Beck disease, which occurs only in Manchurian hunters and is related to their drinking water. It contains fantastic quantities of iron in certain provinces of Manchuria. As young hunters move more away from this area because of scarceness of game, they lose their hemochromatosis. People always bring up Bantu's disease. He was not a Bantu, or if so Dr. Carter held it off, and also if the Bantus leave their land they also usually lose their hemochromatosis, and this man lived at least for four years around Columbus. Otherwise I don't know of any disease that should be mentioned in the differential diagnosis.

### General Clinical Discussion

DR. VON HAAM: What was the primary basis for your diagnosis? Do the iron findings clinch it?

DR. WALL: No. This is the confusing thing

about this. Most hemochromatosis people will have a serum iron in excess of 200 mcg. per cent and they will be pretty well saturated. This man was saturated 100 per cent but his serum iron was only 99 mcg. per cent. I would thing that the diagnosis was made on the liver biopsy because they merely went along phlebotomizing him.

STUDENT: Why do you suspect a hepatoma?

DR. WALL: I think you have to explain this rapidly failing liver. It was failing too fast for a hemochromatosis patient. It might also be a very good explanation why his serum irons were so fouled up.

DR. HAMWI: We have had some patients with relatively mild diabetes and liver cirrhosis who responded beautifully on Orinase or oral hypoglycemic agents.

DR. WARREN: What is your impression of the basic metabolic disturbance in hemochromatosis?

DR. WALL: There are really conflicting stories. It probably has to do with an increased iron uptake. The most exact studies that I have seen suggest that after phlebotomy everybody gets an increase in iron uptake, but the hemochromatosis patient seems to get a bigger uptake. The increase would have to be only 3 to 5 per cent over a long period of time to account for the increase in our body iron.

### CLINICAL DIAGNOSIS

1. Hemochromatosis with cirrhosis and diabetes mellitus.
2. Primary carcinoma of the liver.
3. Terminal hemorrhage from esophageal or gastric varices.
4. Bronchiectasis.

### PATHOLOGICAL DIAGNOSIS

1. Hemochromatosis with cirrhosis and chronic pancreatitis.
2. Primary carcinoma of the liver.
3. Esophageal varices with massive gastrointestinal hemorrhage.
4. Pulmonary emphysema with chronic bronchitis and bronchiectasis.

### PATHOLOGICAL DISCUSSION

DR. VON HAAM: The liver biopsy taken on his first admission showed cirrhosis with marked deposition of iron pigment. Subsequent biopsies revealed persistent cirrhosis with some atypical liver cell changes, but iron pigment could no longer be demonstrated. At autopsy the dark color of the skin was still present. No icterus was noted. The abdominal cavity contained approximately 6000 cc. of clear yellow fluid. The heart appeared of normal size. The lungs showed numerous emphysematous blebs and mild bronchiectasia of the right lower lobe. The liver was enlarged and finely nodular with one multinodular whitish area in the right liver lobe. The cut surface showed numerous fine grayish-yellow nodules scattered throughout the liver tissue. The esophagus showed large varicose veins with superficial erosion of the overlying mucosa. The stomach and intestines were filled with blood suggesting a severe hemorrhage with intractable shock.

### Microscopic Examination

Microscopic examination of the heart showed mild hypertrophy. Iron stains failed to demonstrate any deposits of iron within the muscle fibers. Sections through the lung confirmed the bronchiectasia with chronic bronchitis. Small metastatic tumor nodules were present throughout the lung parenchyma. Sections through the liver showed a cirrhosis of the nutritional type without any demonstrable pigmentation. The tumor node proved to be a mixed type of primary carcinoma, showing the hepatocellular as well as the bile duct cell type. Numerous atypical precancerous changes were found in the degenerating liver tissue. Iron stains of the liver sections failed to demonstrate any iron deposits.

Sections of the spleen revealed old foci of iron incrustation (Gamna-Gandy bodies), suggesting that the patient suffered from periods of hemolytic crisis. Sections through the pancreas showed a severe fibrosis with comparatively little inflammatory changes and no pigment deposits. Many of the islands of Langerhans appeared destroyed; others were small and comsisted mainly of alpha cells. The adrenal glands contained a small metastatic nodule. Sections through the kidney showed evidence of moderate benign nephrosclerosis. Sections through the skin revealed some melanin deposited in the basal cells of the skin and an occasional melanophore in the subepidermal tissue. Iron stains were again completely negative.

*In summary* then, we felt that the patient suffered from nutritional cirrhosis with primary hepatoma and died from severe hemorrhage from his esophageal varices. At the time of death no traces were found of his former hemochromatosis which was obviously recognized in the first liver biopsy and which also was responsible for the severe fibrosis of the pancreas with diabetes. It must be therefore concluded that his hemochromatosis was cured by the numerous phlebotomies which the patient underwent. The possibility of this has been attested to in the recent literature, and Davis and Arrowsmith[1] report the disappearance of iron pigment from the liver by this therapeutic measure. Well in accord with the diagnosis of hemochromatosis is also the appearance of hepatoma. It is a well known fact that hepatic carcinoma is at least twice as common in this condition as in nonpigmented cirrhosis of the liver.[2]

### References

1. Davis, W. D., and Arrowsmith, W. R.: Treatment of Hemochromatosis by Massive Venesection. Ann. Int. Med., 39:723-734, 1953.

2. Warren, S., and Drake, W. L., Jr.: Primary Carcinoma of the Liver in Hemochromatosis. Amer. J. Path., 27:573-610, 1951.

# Maternal Deaths Involving Cardiac Disease

By the OSMA COMMITTEE ON MATERNAL HEALTH

IN THE ten leading causes of death during 1959 in the United States, vital statistics again place "Diseases of the Heart" at the top of the column, in a position of questionable distinction. From the Ohio Maternal Mortality Study, the Committee's report for the year 1958 (November 1961 issue of *The Journal)* carried only *three* maternal deaths due to cardiac disease compared to *eight* cardiac maternal deaths for 1957. Although this apparent lull in the prevalence of a cause of maternal deaths is pleasantly pacifying, we constantly seek more information on this scientifically fascinating phenomenon. Below, The Committee presents three case reports of patients who died undelivered, during pregnancy, with organic heart disease.

## Case No. 339

This patient was a 24 year old, white, gravida IV, Para III, who died undelivered during her eighth month of gestation. She was known to have a cardiac abnormality, enlargement with a mitral murmur; other details were *not* recorded. She was "always rather delicate." Three previous pregnancies were delivered spontaneously at term, apparently without complication. With her last period March 23, she registered with the physician in the third month of pregnancy; she made six visits besides her hospitalizations. The patient's prenatal course (noting the cardiac findings) was uneventful until October 2 (27 weeks), when she developed a severe "cold"; she was hospitalized! Recovery was prompt and after six days she was discharged. The chest x-ray "showed no pulmonary condition."

Suddenly, November 12 (33 weeks) she became acutely ill, was brought to the hospital and admitted at once, where medical consultation was obtained immediately. The patient was apprehensive, dyspneic, toxic and cyanotic. Physical findings indicated an atypical pneumonia, the heart slightly enlarged to the left with a rough diastolic murmur in the axilla. The uterine fundus "was three fingers above the umbilicus" with fetal heart tones questionable, due to groaning of patient. *Diagnosis:* atypical pneumonia, rheumatic heart disease with mitral stenosis. Laboratory work revealed a leukopenia and a scant growth of non-hemolytic *Streptococci,* hemolytic *Staphylococci (albus).* X-ray (portable): "homogenous density in left lung field — may represent a pneumonia or a pulmonary infarct — roentgenologic evidence of a rheumatic lesion, with 10 to 15 per cent enlargement."

Treatment included oxygen, antibiotics, digitalis, hydrocortisone, Thiomerin® and Demerol.® She was desperately ill! In spite of all therapy, the patient pursued a downhill course and died November 13. A postmortem cesarean section delivered a premature (size) stillborn fetus. Autopsy was permitted.

*Pathological Diagnosis:* Healed rheumatic endocarditis, mitral stenosis, moderate non-deforming disease of aortic and tricuspid valves, scarring of left atrial endocardium; atypical pneumonia, diffuse, bilateral, especially lower left lobes; parturient uterus.

### Comment

The Committee studied this case with great interest, noting particularly that both records, scope of diagnostic effort and therapy were complete! High points of discussion centered about the influence of the pregnancy upon the acute respiratory condition and adverse effects of the old cardiac lesion upon normal physiologic efforts of the patient to overcome the acute disease. Members, feeling that the stress of pregnancy adversely influenced the patient's outcome, voted this case a nonpreventable maternal death.

## Case No. 342

This 33 year old, white, gravida III, Para II died, undelivered at 39 weeks (?) gestation, without labor. The brief records do not indicate any illness or surgery in the patient's history; no definite history of rheumatic fever. Throughout the years the patient was obese, weighing 200 pounds or more. There were two previous term (36 week?) pregnancies delivered at term, more than 10 years ago. In the third pregnancy the patient registered with her family physician in the second month (April 16), and made eight subsequent prenatal visits. From the physician it was learned that her prenatal course was uneventful; the initial examination revealed no abnormal findings; her weight was 207 pounds, blood pressure 120/60 (highest 140/80, once), urinalysis negative, heart and lungs normal. Throughout her pregnancy the patient actually lost several pounds of weight. Her last antenatal visit was October 27 (37½ weeks). The husband stated that November 11 his wife arose, passed blood-stained mucous discharge per vagina, stated she "felt faint," slumped to the floor and passed into coma. An ambulance was summoned to remove the patient to the hospital; on arrival she was pronounced dead. An autopsy was performed.

*Pathological Diagnosis:* Acute passive congestion of organs and pulmonary edema, due to: myocardial insufficiency, due to: subendocardial necrosis and ischemia; prolonged vasospasm, secondary to; toxemia of pregnancy; fatty degeneration of the heart; central lobular necrosis of liver; chronic cholecystitis and cholelithiasis; term pregnancy with uterine death of term female (3720 grams); varicosities, lower extremities; obesity.

### Comment

Committee members reviewed facts in this tragic case with keen interest. One questioned the possibili-

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

ty of the patient being a prediabetic, with superimposed acute toxemia. Further proof was lacking from the scanty records in the case, including weights of her previous infants at birth. Although histologic examination revealed liver findings commensurate with eclampsia, the clinical story did not include convulsions, etc. The Committee voted the case a nonpreventable maternal death (unavoidable catastrophe).

## Case No. 343

This patient was a 34 year old, white, gravida II, Para I, who died undelivered at 36 weeks gestation. She was a "known cardiac" who had had rheumatic fever at 14 years of age, with a recurrence at 23 years of age! (Curiously enough, her sister also had had rheumatic fever with subsequent cardiac disease.) The only surgery was an appendectomy. When she was 21, the patient delivered a living fetus at term without complication of pregnancy or parturition. However, for the past eight years the patient (residing in Florida) had noted dyspnea on exertion and occasional pedal edema.

With her last menstrual period February 26, the patient had had only one or two prenatal visits to her physician; Cedilanid® tablets, one three times a day, were prescribed when some edema of the feet appeared during pregnancy. October 15 the patient came to Ohio (at 33 weeks) and registered with her physician. Her sole complaint was occasional "exertional dyspnea"; blood pressure was 108/68, one plus edema of the feet, cardiac enlargement and loud, rough apical systolic and presystolic cardiac murmurs. The physician prescribed a low sodium diet, iron and calcium supplement, Cedilanid was continued, and sulfadiazine was prescribed (prophylactic) because of a history of "strep throat" a month previously. Daily bed rest on a systematic schedule was prescribed also, and October 19 a consultant examined her and confirmed the diagnosis of rheumatic mitral stenosis. The electrocardiogram was "borderline"; P waves resembled the type seen with early right ventricular hypertrophy. However, the consultant felt that the patient should be evaluated for mitral commissurotomy *after* delivery.

On October 29 (35 weeks) the patient had gained several pounds; she had a 'cold' with a nonproductive cough, although her lung fields were clear. Penicillin and an antitussive were prescribed, along with additional bed rest. The following day she developed a fever of 101°, dyspnea, orthopnea and a severe cough with moist rales in the right lung base. She was admitted at 11:15 p. m. and given morphine, penicillin and Cedilanid. Consultation was obtained again. The patient's temperature rose to 103°, pulse rate 120 per minute, blood pressure 92/60. The cardiac rhythm was regular, although her nail beds were cyanotic.

Penicillin, streptomycin, Signemycin,® Mercurhydrin,® and nasal oxygen comprised the principal therapy. It was felt that over and above congestive heart failure, bronchopneumonia had developed. This was confirmed by x-ray. Bloody sputum was expectorated as the patient developed oliguria. She pursued a downhill course in spite of therapy and died November 1. Five minutes after death, a postmortem cesarean section was performed, delivering a stillborn fetus (physicians could not be sure the fetal heart had disappeared because of the patient's restless condition). Autopsy was permitted.

*Pathological Diagnosis:* Acute pulmonary edema; bronchopneumonia; rheumatic heart disease; mitral stenosis; 36 week uterine pregnancy.

## Comment

Members of the Committee remarked that the records in this case were complete in detail, and felt that a high quality of care was given to the patient during her last two weeks. It was apparent, however, that the patient should have sought regular prenatal care for the *early* part of her pregnancy, in view of her cardiac history. When a vote was called, the Committee was nearly divided on the preventable (avoidable) factor in the death; but by a narrow margin, finally it was voted a nonpreventable maternal death.

## Comment of Cardiac Consultant

The following comment of a consultant, who is a specialist in cardiac disease, was furnished at the request of the Committee:

"With respect to **Case No. 339**, this 24 year old woman had mitral stenosis and pneumonia. I would disagree somewhat with the vote that this was a nonpreventable death. It seems that the patient might have shown some evidence of pulmonary congestion when she had her 'cold.' Our own experience would indicate that women with heart disease have to be followed exceedingly closely by both an *obstetrician* and a *cardiologist*. These women can deteriorate rapidly and may have to be hospitalized for as long a period as the last two months of their pregnancy where 24-hour service by attending and house staff is necessary. The bed rest takes the work load off the heart; morbidity and mortality-producing phenomena can be detected earlier and measures to alleviate such can be promptly instituted.

"With respect to **Case No. 342**, I would heartily agree that this was a nonpreventable death. Of course, the patient could have lost weight but in reading over the data there is nothing to lead one to suspect subendocardial necrosis. I don't know how one would have treated this patient differently.

"With respect to **Case No. 343**, I think many of the same comments are applicable here that were made concerning Case 339, namely, evidence of pulmonary congestion manifested by the complaint of exertional dyspnea. She might well have also been admitted to the hospital for the last two months of pregnancy. At 35 weeks she had further congestion with weight gain and 'cold' and should have been admitted then. She again demonstrated how quickly a parturient with heart disease, especially mitral stenosis can develop pulmonary congestion, pneumonitis and death. I would likewise partially disagree with the vote of the Committee and call this a preventable death using, as I say, the same reason used in Case 339. Closer supervision might have permitted this woman to get through her pregnancy. Both Case 339 and Case 342 had mitral stenosis which conceivably could have been corrected surgically. In my opinion it should have been done in the non-pregnant state because the mortality is lower for non-pregnant than for pregnant women. Had these two women gotten through pregnancy they might have been symptomatically improved with surgery. This then makes these considered preventable deaths in surgically correctible lesions. Further, if an error was made, it was in not employing hospitalization soon enough."




# NEWS AND Organization Section

# Proceedings of The Council

## Policy Statements on Osteopathy and AMPAC Adopted at Dec. 16-17 Meeting; Budget for Year 1962 Is Established

A REGULAR MEETING of The Council of the Ohio State Medical Association was held on December 16 and 17, 1961, at the Columbus Office of the Association. The following were in attendance in addition to members of The Council: Drs. Richard L. Meiling, Columbus, Charles A. Sebastian, Cincinnati, C. C. Sherburne, Columbus, George A. Woodhouse, Pleasant Hill, Edmond K. Yantes, Wilmington, delegates to the AMA; Drs. T. L. Light, Dayton, Robert S. Martin, Zanesville, Paul F. Orr, Perrysburg, H. T. Pease, Wadsworth, P. John Robechek, Cleveland, J. Robert Hudson, Cincinnati, alternate-delegates to the AMA; Dr. H. M. Clodfelter, Columbus, president, and Mr. Charles H. Coghlan, Columbus, executive vice president, Ohio Medical Indemnity, Inc.; Mr. Robert A. Lang, Cleveland, executive secretary of the Cleveland Academy of Medicine; Dr. Perry R. Ayres, Columbus, Editor, *The Ohio State Medical Journal;* Mr. Wayne E. Stichter, Toledo, legal counsel; Dr. Robert M. Bartlett, president, and Mr. Sidney H. Mountcastle, executive secretary of the Summit County Medical Society; and Messrs. Nelson, Saville, Page, Edgar and Moore from the headquarters staff.

### Need Reports Promptly

In opening the meeting Dr. Petznick urged Councilors to in turn urge their county medical societies to report new officers for 1962 as promptly as possible, especially so invitations can be issued soon to the County Society Officers Conference on Sunday, February 25, at the Deshler-Hilton Hotel, Columbus. Dr. Petznick also called attention to the red handbook for county society officers which will be issued to new officers as their names are reported to the Columbus office.

### Minutes Approved

Minutes of the meeting of The Council held at Granville on September 15-17 were approved by official action.

### Membership Report

Executive Secretary Nelson reported membership statistics as follows: Ohio State Medical Association membership as of December 12, 1961, 9,515, compared to 9,370 on December 31, 1960. The report showed that 8,610 of the OSMA members had affiliated with the AMA as of December 12, compared to 8,391 as of December 31,1960.

### Federal Legislation

Mr. Nelson gave a detailed run-down on the status of federal legislation, especially H. R. 4222. He pointed out that contacts had been made with Ohio congressmen; that new material had been obtained and added to the speakers' bureau packet; that part of the program of the County Society Officers Conference on February 25 would be devoted to a discussion of legislative matters and that information had been received from the American Medical Political Action Committee advising that it is now organized and ready to do business.

### Resolution on AMPAC

After discussing the American Medical Political Action Committee, The Council adopted the following resolution on this subject:

WHEREAS, Through the impetus of the American Medical Association, a voluntary, nonprofit, unincorporated organ-

ization known as the American Medical Political Action Committee has been established with headquarters at 520 North Michigan Avenue, Chicago, and

WHEREAS, the purposes of AMPAC are:

(a) To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.

(b) To encourage physicians and others to understand the nature and actions of their government, as to important political issues, and as to the records, officeholders and candidates for elective office.

(c) To assist physicians and others in organizing themselves for more effective political action and in carrying out their civic responsibilities.

(d) To do any and all things necessary or desirable for the attainment of the purposes stated above.

WHEREAS, Membership in AMPAC is open to licensed doctors of medicine, their spouses, members of their immediate family and employees of nonprofit medical societies or associations, active membership dues being $10 and sustaining membership dues being $99, annually, therefore

BE IT RESOLVED, That The Council of the Ohio State Medical Association:

(1) Endorses the formation and purposes of the American Medical Political Action Committee;

(2) Urges members of the Ohio State Medical Association and members of their family, when called upon to assist in financing AMPAC, to do so by becoming a member of AMPAC or by making a voluntary financial contribution;

(3) Requests members of the Ohio State Medical Association to actively support and cooperate with AMPAC in furthering its educational activities and other objectives.

### Report on Fall District Conferences

Mr. Saville, Director of Public Relations, submitted a report regarding the 1961 Fall District Conferences. He pointed out that they had been exceptionally well attended and that 69 of the 88 county medical societies were represented at the meetings.

### American Medical Education Foundation

Mr. Saville also reported on the status of the American Medical Education Foundation campaign in Ohio. He stated that 1,545 contributions to the 1961 Ohio campaign in behalf of the American Medical Education Foundation totalled $44,734.80 as of November 30. Comparable figures on the same date in 1960 were $31,317.02 by 735 donors. He also announced that effective January 1, 1962, the programs of AMEF and the American Medical Research Foundation will be consolidated within the framework of a single Foundation — the American Medical Association Education and Research Foundation. These programs will be expanded and a concerted effort made to provide increased financial assistance to medical schools, in addition to financing other projects of the Foundation.

### Reports by Councilors

Reports on activities in their districts were presented by members of The Council.

### Financial Report

At this point The Council went into executive session to consider the report of the Committee on Auditing and Appropriations. The report and recommendations of the committee, which had met all day Saturday, December 16, were approved by unanimous action of The Council. The report included the following budget for 1962:

BUDGET FOR 1962

| | |
|---|---|
| The Ohio State Medical Journal | $ 39,000.00 |
| Executive Secretary, Salary | 20,000.00 |
| Executive Secretary, Expense | 2,5000.0 |
| Administrative Assistant, Salary | 12,100.00 |
| Administrative Assistant, Expense | 2,500.00 |
| Stenographic and Clerical Salaries | 41,860.00 |
| President, Expense | 4,000.00 |
| President-Elect, Expense | 2,500.00 |
| Council, Expense | 6,000.00 |
| American Medical Association Delegates | 14,400.00 |
| **Dept of Public Relations ($43,600)** | |
| Director, Salary | 17,500.00 |
| Director, Expense | 2,500.00 |
| Assistant Director, Salary | 13,600.00 |
| Assistant Director, Expense | 2,500.00 |
| Exhibits and Newspaper Publicity | 500.00 |
| Literature | 1,000.00 |
| Postage | 2,500.00 |
| Supplies | 500.00 |
| Miscellaneous Activities | 3,000.00 |
| **Committees:** | |
| Education | 250.00 |
| Judicial and Professional Relations | 400.00 |
| Public Relations and Economics | 400.00 |
| Scientific Work | 900.00 |
| Auditing and Appropriations; Bookkeeping | 1,000.00 |
| Cancer | 250.00 |
| Care of the Aged | 600.00 |
| Disaster Medical Care | 500.00 |
| Eye Care | 300.00 |
| Hospital Relations | 400.00 |
| Laboratory Medicine | 700.00 |
| Maternal Health | 1,500.00 |
| Mental Hygiene | 250.00 |
| Occupational Health | 400.00 |
| Poison Control | 400.00 |
| Radiation | 400.00 |
| Rural Health | 1,800.00 |
| School Health | 2,500.00 |
| Traffic Safety | 400.00 |
| Miscellaneous | 200.00 |
| Annual Meeting | 25,000.00 |
| Conference County Society Officers | 2,000.00 |
| Councilor District Conferences | 3,000.00 |
| Emergency and Equipment Fund | 1,000.00 |
| Employees' Retirement Fund | 8,450.00 |
| Insurance and Bonding and Social Security | 5,500.00 |
| Lectures for Senior Medical Students | 2,500.00 |
| Legal Expense | 10,000.00 |
| Library | 400.00 |
| OSMAgram | 3,500.00 |
| Postage | 2,500.00 |
| Professional Relations Activities | 4,500.00 |
| Rent and Utilities | 13,300.00 |
| Rural Medical Scholarships | 2,000.00 |
| Stationery and Supplies | 5,600.00 |
| Telephone and Telegraph | 4,000.00 |
| Woman's Auxiliary Contribution | 1,500.00 |
| TOTAL | $296,760.00 |

### Increase in Annual Dues Proposed

One of the important recommendations made by the committee was that The Council should present a resolution to the House of Delegates in 1962 for an increase in the annual dues of the Association from $30 to $35, effective January 1, 1963. This recommendation was approved unanimously by The

Council and the Executive Secretary was authorized to prepare a statement setting forth reasons for the increase in dues based on the discussion at the Council session.

### Constitutions and Bylaws

Action was taken by The Council on a number of county society constitutions and bylaws which had been submitted for approval. By official action, approval was given to the new constitutions and bylaws of the Auglaize County Medical Society, Jackson County Medical Society and Mercer County Medical Society. An amendment to the constitution and bylaws of the Darke County Medical Society authorizing an increase in dues also was approved.

### Judicial and Professional Relations Committee

The Executive Secretary presented a report from the Judicial and Professional Relations Committee, based on a meeting of that committee held on October 22, 1961. The Council, by official action, approved the report of the committee. This report recommended that there be no change in the procedure of the Ohio State Medical Association for the holding of a referendum, a question which the committee had been asked to explore pursuant to a resolution by the House of Delegates in 1960.

### Osteopathic Question

This report also presented a proposed statement of policy on the relationship between doctors of medicine and doctors of osteopathy in Ohio which had been compiled after an extensive study by the committee. The Council, by official action, approved this statement of policy and authorized that it should be transmitted to each county medical society for its guidance (see page 191 this issue of *The Journal*).

Among those who participated in the discussion of the osteopathic question were Dr. Bartlett and Mr. Mountcastle. They reviewed the situation in Akron with regard to an osteopathic hospital. Both expressed the hope that the status quo could be maintained. They stated they felt this subject should be covered by a national policy or, at least, by a state-wide policy, indicating that they believed it would be difficult to handle on a local basis. Others who took part in the discussion expressed the opinion that the question has to be resolved on a local basis, the same as other situations involving ethics and professional relations.

### Home Care Program

Drs. Robechek and Yantes discussed a special report from the Committee on Care of the Aged pertaining to a proposed home care program for the State of Ohio. Drs. Robechek and Yantes are members of that committee and participated in the drafting of the home care proposal. Mr. Edgar also commented on the report. By official action, The Council approved the proposed home care program to be issued as a guide to local organizations interested in this subject.

### Committee on Hospital Relations

Dr. Paul F. Orr, chairman of the Committee on Hospital Relations, presented a report from that committee, based on a meeting held on November 19, 1961 in Columbus.

This report reviewed the legal and ethical problems arising from authentication of hospital charts and records. The committee stated that in its opinion the responsibility of the attending physician and members of the house staff as to signing reports, chart entries, summary sheets, etc., are adequately covered by the rules of the Joint Commission on Accreditation of Hospitals as set forth in certain paragraphs from "Hospital Accreditation References, 1961 Revision" and should be observed by each hospital and its staff. It was the committee's recommendation that, inasmuch as the Joint Commission has held that a single signature of the attending physician on the face sheet or summary of the medical record does not suffice to authenticate the entire content of the record, blanket authentication clauses may be eliminated from such forms at the discretion of the hospital.

The committee reported also that it had devoted a large part of the meeting to the problem of staffing of hospital emergency rooms and that this question would be taken up again by the committee at a meeting in the very near future.

The report of the Committee on Hospital Relations was approved by official action of The Council.

### Committee on Workmen's Compensation

The Executive Secretary presented a report on behalf of the Committee on Workmen's Compensation, based on a meeting of that committee held on October 18, 1961 in Columbus.

The report pointed out that certain increases in the Bureau of Workmen's Compensation Fee Schedule had recently been approved by the Bureau and would become effective January 1, 1962. (See page 70 January issue of *The Journal.)*

The rest of the report was devoted to specific cases and subjects on which the committee had submitted recommendations to the Bureau of Workmen's Compensation and was awaiting action by the Bureau.

By official action, The Council approved the report of the Committee on Workmen's Compensation.

### Committee on Maternal Health

Mr. Page, reporting for the Committee on Maternal Health, reviewed the minutes of a meeting of that committee held on September 24, 1961. By official action, the report of the committee was approved.

### Cancer Coordinating Committee

Mr. Edgar reported for the Cancer Coordinating Committee, his report being based on a meeting of the committee held on December 10, 1961. The

report stated that the committee had decided to step up its activities with respect to the establishment of more local cancer registries. Also, the report carried a recommendation endorsing the 1961 Hospital Tumor Registries program of the American College of Surgeons. By official action, the report of the Cancer Coordinating Committee was approved.

### Committee on Radiation

Mr. Nelson reported for the Committee on Radiation, based on the minutes of a meeting of that committee held on November 12, 1961 in which certain specific activities of the committee for the future were outlined. By official action, the report of the committee was approved.

### Committee on Rural Health

Reporting for the Committee on Rural Health, based on a meeting of that committee held on December 6, Mr. Edgar stated that the committee had considered a request from The Council that it review possible increases in the rural medical scholarship program and types of scholarships to be made available. He reported that the committee voted to recommend to The Council that it would not be feasible to increase the scholarship until the budget of the Association became more adequate but that this matter be considered when the budget might warrant such an increase. Also, it was pointed out that the committee felt that contacts should be made with the AMA regarding its scholarship program to see if scholarships could be issued on a geographical basis, particularly for students coming from rural areas or planning to practice in rural areas.

Mr. Edgar pointed out that the talks for medical students would be held at Ohio State University on January 20 and at the University of Cincinnati on February 11 under the sponsorship of his committee. Also he commented on the great success of the district rural health conferences held throughout the state last fall in which the OSMA played a major part. By official action, the report of the Committee on Rural Health was approved.

### Joint Advisory Committee on Athletic Injuries

Mr. Page reported for the Joint Advisory Committee on Athletic Injuries which had met on October 2, 1961 and that report was adopted by official action.

It was reported by Mr. Page that a Postgraduate Institute for Physicians on Medical Aspects of High School Athletics would be held at the Ohio State University College of Medicine on August 29-30, 1962.

### Special Insurance Committee

A report from the Special Insurance Committee which had met on October 24, 1961 was submitted by the Executive Secretary. A request of the committee for permission to make a survey of the membership of the Association as to the needs and desires of the members for insurance coverage such as business overhead, major medical, health and accident and accidental death and dismemberment was approved by official action of The Council.

### State Medical Journal Conference

Reports by Dr. Ayres and Mr. Moore on a conference held in Chicago on October 30 and 31, 1961, attended by representatives of various state medical journals, were presented by them for the information of The Council. The Council expressed commendation to them for their reports and work on *The Journal*.

### Ohio Medical Indemnity, Inc.

Drs. Clodfelter and Yantes and Mr. Coghlan presented a report from Ohio Medical Indemnity, Inc. In the reports particular reference was made to the loss by Ohio Medical Indemnity of the accounts of General Motors, Ford and Chrysler Motor Car Companies to the Metropolitan Life Insurance Company, the John Hancock Life and the Aetna Life Insurance Companies, respectively.

Representatives of OMI reported that plans are under way to improve the coverages which OMI will offer to its 2,454,000 enrollees. The active support and cooperation of The Council and all members of the Ohio State Medical Association on these ventures was requested.

Representatives of OMI also reported that a general state-wide educational program will be launched in the very near future to acquaint the general public with the good coverages offered by OMI in its preferred and major contracts.

A communication from the Hospital Care Corporation, Cincinnati, regarding the loss of the motor car company contracts by Ohio Medical Indemnity was discussed. The Executive Secretary was authorized to advise that organization that Ohio Medical Indemnity has plans under way to expand its coverage to meet this and future challenges.

### Review Committees Requested

A communication from the Health Insurance Council, on behalf of the Metropolitan, John Hancock and Aetna Insurance Companies, was read and discussed. This letter specifically asked The Council and the 88 county medical societies in Ohio to establish so-called review committees for the purpose of giving expert advice to the companies as to whether or not physicians' charges are customary and reasonable and whether or not the services rendered were necessary, whenever such differences of opinion should arise.

### Statement Adopted

After a very thorough discussion of this subject, The Council adopted the following statement and instructed the Executive Secretary to transmit it to the Health Insurance Council:

"It is suggested by The Council of the Ohio State Medical Association that insurance companies make

use of the regular grievance and mediation program of the Association and its component county medical societies when and if they desire advice on the adjustment of differences between them and members of the medical profession. Facilities are available through most of the 88 county medical societies.

"Under the existing policy of the Ohio State Medical Association on the handling of grievances as adopted by The Council, December 12, 1953, complaints may be investigated and settled, if possible, by The Council should the county medical society to which the physician belongs not have facilities for handling such matters or in event the local committee fails to conduct an investigation of a case, which in the opinion of The Council, warrants investigation. Moreover, The Council is authorized to serve as a 'court of appeals' when local conditions make it difficult for a component society to conduct a thorough and impartial hearing."

### National Congress on Prepaid Health Insurance

Dr. Tschantz and Dr. Martin and Mr. Coghlan reported on the Second National Congress on Prepaid Health Insurance held on October 14-15, 1961 in Chicago. This was sponsored by the American Medical Association. They had acted as official representatives of the OSMA.

### Denver AMA Meeting

Dr. Woodhouse submitted a report on behalf of Ohio's delegates and alternate-delegates at the recent session of the American Medical Association at Denver. Others who attended the Denver meeting also submitted brief verbal reports. There was a lengthy discussion not only on the Denver meeting but also on plans for the June, 1962 meeting in Chicago. (See page 67 January issue *The Journal* for story on AMA meeting.)

### Conferences in Cleveland

Mr. Saville, Mr. Edgar, Mr. Lang, Dr. Petznick and others reported on the National Conference of the Church and Social Welfare held in Cleveland on October 23-27, 1961 and on the "Little White House" Regional Conference held in Cleveland on November 14-15, 1961. It was emphasized in these reports that Mr. Lang and other representatives of the Cleveland Academy of Medicine who had attended these conferences had done a splendid job in the discussion groups, indicating that the preparation of the Cleveland Academy and their willingness to participate in meetings of this kind is paying real dividends. Those who attended and participated in these meetings were officially commended by The Council.

### Nurses and Intravenous Therapy

A proposed statement on the role of the professional nurse in the administration of intravenous therapy was considered and received the official approval of The Council. This proposed statement had been prepared as a result of a joint meeting several months ago of representatives of various professional groups called by the Ohio State Nurses Association. (After the statement has been officially approved and adopted by the Ohio State Nurses Association, information on this will be disseminated to the county medical societies and OSMA membership.)

### OMI Nominating Committee

Dr. Petznick appointed the following as a nominating committee to bring in a slate of nominees for the Board of Directors of Ohio Medical Indemnity for action by The Council at its next meeting and for consideration of the OMI stockholders in April: Dr. Charles W. Hoyt, Cincinnati, chairman; Dr. Henry A. Crawford, Cleveland; and Dr. Lawrence C. Meredith, Elyria.

### Increase in Malpractice Insurance Rates

The Executive Secretary reported on slight increases, effective November 29, 1961, in Ohio on malpractice insurance coverage by companies belonging to the National Bureau of Casualty Underwriters. Reference was made to the new rates in the October, 1961 issue of *The Ohio State Medical Journal,* page 1158.

### OSMA Group Insurance Plan

A report was received from the Turner and Shepard Insurance Agency on the status of the Ohio State Medical Association group insurance plan as of September 1, 1961 showing a total coverage of 2,693 persons.

### Dr. Orr Commended by AAMA

A letter from the president of the American Association of Medical Assistants, commending Dr. Paul F. Orr, Perrysburg, a former member of this Council, for his outstanding service to that association as a member of its Advisory Board, was read and discussed. By official action, Dr. Orr was thanked for his work in this capacity.

### Division of Aid for the Aged Matter

A communication from the Knox County Medical Society, protesting the action of the Division of Aid for the Aged in not paying an adequate amount for influenza injections, was read and discussed. By official action, The Council voted to submit the matter to Drs. Hamwi and Inglis for discussion with Dr. William F. Bradley, chairman of the Medical Advisory Committee of the Division of Aid for the Aged.

### OAGP Resolutions

Three resolutions adopted by the Ohio Academy of General Practice last September were discussed. It was felt that no additional action was needed with respect to these resolutions inasmuch as the subject of osteopaths already had been acted upon by The Council; the subject of brand names vs. generic named drugs is in line with the existing policy of the

OSMA; and the third resolution on Workmen's Compensation fees has been disposed of by action of the Bureau of Workmen's Compensation in increasing fees for certain medical procedures.

### Pharmacy Regulation Approved

A proposed regulation submitted by the Board of Pharmacy to the Ohio Public Health Council for action, regarding the necessity for authorization from a physician before a pharmacist shall dispense a drug of a different brand than prescribed by a practitioner, was approved by official action.

### Physician-Hospital Radio System

A suggestion that the Ohio State Medical Association request the Federal Communications Commission to assign a special frequency for all physician-hospital radio systems throughout the State of Ohio was discussed. The Executive Secretary was authorized to proceed with the Federal Communications Commission on this matter and to have such a program inaugurated in Ohio, if possible, providing there would be no expense to the Association.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
*Executive Secretary.*

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## New Highs in Voluntary Health Insurance

In 1961, the health insurance business reached new highs both in the number of persons covered and in the amount of benefits paid out, the Health Insurance Institute reports. It estimated that as of Dec. 31, 1961, some 136 million persons — or 75 per cent of the civilian population — were protected by some form of health insurance, an increase of four million over the record figure of 132 million reached in 1960.

The Institute also estimated that benefit payments during 1961 totaled $6.3 billion, an increase of about 11 per cent over the record $5.7 billion paid out in 1960.

In addition to the 136 million protected against the cost of hospital care at the end of last year, it was estimated that 124 million persons had surgical expense insurance, 91 million had regular medical expense insurance, 35 million had major medical insurance provided by insurance companies, and 43 million had loss of income protection.

An estimated 9,000,000 persons aged 65 or over — approximately 53 per cent of Americans in that age category — were covered in 1961 by one or more types of health insurance, the Institute said.

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The West Virginia Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia, on April 23-25, 1962.

## OSMA Views On Drivers' Licenses Endorsed

The Health and Medical Section of the Governor's Traffic Safety Conference has urged the Ohio Department of Highway Safety to give serious consideration to the Ohio State Medical Association's recommendations concerning licensing of motor vehicle operators.

At the annual conference held in Columbus in December, the section urged the department to seriously consider the OSMA recommendations, prepared by the Committee on Traffic Safety, concerning physical and mental requirements for obtaining and retaining a motor vehicle operator's license in Ohio.

Other recommendations made by the section include:

1. That communities survey their transportation of the injured to determine the scope of the problem and how it can be improved in the areas of:
   A. Emergency care at the scene of the accident.
   B. Transportation of the injured.
   C. Emergency care at the hospital.
2. State and local agencies and organizations be encouraged to develop a coordinated approach to the problem of providing services for the care and transportation of the injured, including supervision and licensure of emergency vehicle attendants.
3. The development of professional and lay information on the effects of certain commonly used drugs on the ability to drive a motor vehicle.
4. That seat belts be installed and used in all government-owned motor vehicles — both as an actual safety feature and as an added inducement to help get the general public to accept and use these proven safety items.

The section recommendations came following a panel discussion, including audience participation, moderated by Frederick Wentworth, M. D., assistant director, Ohio Department of Health.

Members of the panel included Paul V. Joliet, M. D., and Frank Palmer, U. S. Public Health Service; Don E. Day, Ohio Department of Health, and Charles W. Edgar, Secretary of the OSMA Committee on Traffic Safety.

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## American College of Physicians

The American College of Physicians has announced several postgraduate programs and regional meetings for the first quarter of this year. Those scheduled in the vicinity of Ohio include the following:

March 5-9, University of Michigan Medical School, Ann Arbor, "Gastroenterology—Basic Principles and Treatment."

March 12-16, University of Chicago Clinics, Chicago, "Selected Subjects in Internal Medicine."

Additional information may be obtained from the organization's headquarters, 4200 Pine Street, Philadelphia 4, Pennsylvania.

# Policy Pertaining to Osteopathy . . .

## Official Statement on Relationship Between M. D.'s And D.O.'s in Ohio Is Adopted by Council of OSMA

A POLICY with regard to relationships between doctors of osteopathy and doctors of medicine in the State of Ohio was adopted by The Council of the Ohio State Medical Association, meeting December 16 and 17, 1961.

The statement, submitted to The Council for action by the Judicial and Professional Relations Committee after extensive study, states that "it is the responsibility of each County Medical Society in Ohio to determine whether it is, or is not, ethical for members of that society to voluntarily associate professionally with doctors of osteopathy" and recommends basic criteria to be used by a County Medical Society in determining the professional, ethical and scientific standing of a doctor of osteopathy, namely:

### Criteria Recommended

"(1) The doctor of osteopathy must have qualified to practice osteopathic medicine and surgery under the Ohio Medical Practice Act as amended in 1943 which confers on him unrestricted rights and legal recognition in Ohio as a physician.

"(2) He must practice a method of healing founded on the principles of scientific medicine.

"(3) He must in good faith endeavor to conform to ethical principles equivalent to the Principles of Medical Ethics of the AMA.

"(4) His professional and scientific competence must be such that he can give his patients scientific medical care and make contributions to programs to maintain and improve the health of the community.

"In the opinion of The Council of the Ohio State Medical Association voluntary professional association between a doctor of medicine and a doctor of osteopathy who meets all the foregoing basic standards would not be deemed unethical."

### Hospital Staff Privileges

On the matter of hospital staff privileges for doctors of osteopathy, the statement of The Council said:

"With respect to hospital staff appointments, The Council's opinion is as follows: The matter of hospital staff membership is a decision for each individual hospital. The same standards used by a hospital in deciding whether staff privileges should be extended to a doctor of medicine should be used in deciding whether staff privileges should be given to a doctor of osteopathy. Inasmuch as it is important that each hospital, if possible, be accredited by the Joint Commission on Accreditation of Hospitals, the policy laid down by the Joint Commission pertaining to hospitals with integrated staffs should be observed."

### Text of Statement

Following is the complete text of the statement drafted by the Judicial and Relations Committee and adopted by The Council as the official policy of the Association:

"At the June, 1961, session of the House of Delegates of the American Medical Association in New York City, the House of Delegates took official action which in effect states that it shall no longer be considered in itself unethical for doctors of medicine to associate professionally and on a voluntary basis with doctors of osteopathy who base their practice on the same scientific and ethical principles as doctors of medicine.

### Action by AMA

"The House of Delegates adopted a statement presented by the Reference Committee on Amendments to Constitution and Bylaws, reading in part as follows:

'1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is, one who does not practice a system of healing founded on a scientific basis.

'2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

'3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

'4. It is appropriate for the American Medical Association to **reappraise its application of policy** regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula

after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

'5. Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test should now be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical.'

"The action in June, 1961, by the AMA House of Delegates climaxed studies of the "osteopathic question" which have been in progress periodically by special committees of the AMA and AMA Judicial Council since 1951. During that time, the question was considered on several occasions by the AMA House of Delegates. However, clearcut definitive action was not taken by the House of Delegates until June, 1961, when it took the action already referred to after receiving a comprehensive report from the Judicial Council which made recommendations on which the House's action was based.

### County Responsibility

"Inasmuch as the application and enforcement of the Principles of Medical Ethics rest, in the first instance, with each County Medical Society under the Constitution and Bylaws of the Ohio State Medical Association, it is the opinion of The Council that it is the responsibility of each County Medical Society in Ohio to determine whether it is, or is not, ethical for members of that society to voluntarily associate professionally with doctors of osteopathy.

"Since, as *The Journal of the AMA* has pointed out editorially, the action taken by the House of Delegates of the AMA 'looks to the facts — not the label,' the verdict in each instance must be based on knowledge of the professional, ethical and scientific competence of the individual doctor of osteopathy under consideration.

"In determining the professional, ethical and scientific standing of a doctor of osteopathy the following criteria are recommended for consideration by the County Medical Society:

### Criteria Listed

"(1) The doctor of osteopathy must have qualified to practice osteopathic medicine and surgery under the Ohio Medical Practice Act as amended in 1943 which confers on him unrestricted rights and legal recognition in Ohio as a physician.

"(2) He must practice a method of healing founded on the principles of scientific medicine.

"(3) He must in good faith endeavor to conform to ethical principles equivalent to the Principles of Medical Ethics of the AMA.

"(4) His professional and scientific competence must be such that he can give his patients scientific medical care and make contributions to programs to maintain and improve the health of the community.

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In the course of a year, the employed population of the United States spent 265 million days in bed as a result of illness or injury, the Health Insurance Institute reports.

### Directory of Rehabilitation Facilities Issued

FOR the first time, a Directory of Ohio Rehabilitation Services and Facilities is now available.

This 100-page directory, data for which were gathered, analysed and compiled by a voluntary committee of the Ohio Rehabilitation Association, briefly describes the services programs of 133 Ohio rehabilitation agencies and lists them by location and nature of services provided. The book includes public and private agencies and facilities which deal primarily with disabled persons and offer one or a combination of medical, social, psychological and vocational services.

Copies may be obtained, at $2.00 each, from Wallace D. Watkins, Chairman, Publications Committee, Ohio Rehabilitation Association, 201 West Fifth Street, Dayton.

# Signing Hospital Records . . .

## Legal and Procedural Questions Answered in Report of Hospital Relations Committee Approved by The Council

CERTAIN legal and procedural questions pertaining to the signing of hospital records were discussed and recommendations offered in a report submitted by the Committee on Hospital Relations to The Council and adopted by The Council on December 16-17.

The specific questions considered were: Is it necessary under the regulations of the Joint Committee on Accreditation of Hospitals to countersign histories, physicals, progress notes, and orders written by house officers? Is the attending physician liable for the acts of the house staff if he signs a medical record which states that the attending physician has assumed the responsibility for the acts and records made by members of the house staff?

### Cites Commission Rulings

In its report the Committee on Hospital Relations stated that in its opinion the responsibilities of the attending physician and members of the house staff are adequately set forth in "Hospital Accreditation Reference, 1961 Revision" which is a compilation of official expressions of the Joint Commission and which should be observed by each hospital and its staff.

Excerpts from the foregoing compilation which are pertinent to the questions under consideration are as follows:

### Should Sign Separately

"**In hospitals without house officers the attending physician should separately sign the history, physical examination, operative report, progress notes, drug and other orders and the summary.** Standing orders should be reproduced on the record and signed by the physician."

"**In hospitals with house officers, the attending physician should countersign at least the history, physical examination and summary written by the house officer.** Aside from the fact that this is a legal requirement in many states, it is a protection to the individual physician. It is not considered necessary to countersign progress notes or drug and treatment orders written by house officers. In all instances a physician should sign the clinical entries which he himself makes."

### Single Signature Not Enough

"**A single signature of the physician on the face sheet of the medical record does not suffice to authenticate the entire content of the record.**" The Joint Commission on Accreditation of Hospitals recommends no specific medical record forms."

"**Each clinical entry should be signed by the attending physician.** This includes the face sheet (usually comprising provisional diagnosis, final diagnosis, operation and condition on discharge) as well as history, physical examination, operative report, progress notes and orders for treatment."

"The specialized reports such as pathology, radiology, anesthesiology, etc., are the responsibility of those participants alone."

"If the house officer (be he intern, resident or paid house officer) takes the history, performs the physical examination, etc., **his entries must be authenticated by the responsible physician in charge with a note as to agreement or disagreement.**"

### Must Assume Responsibility

"**If the attending physician signs only the face sheet, certifying that the contents 'to the best of his knowledge' are accurate, he then takes the responsibility for the reports and entries of the nurses, house officers, consultant specialists, admitting room personnel, etc.**"

"Do all medical records completed by the house staff have to be authenticated by a member of the attending staff? In certain circumstances the entries of interns and residents may be authenticated by another house officer with certain provisos: (1) The authenticating resident shall be senior in educational status (i. e., 3rd, 4th or 5th year). (2) This authenticating resident must hold an unrestricted license in the state. (3) This activity by the senior resident must be approved by the medical staff and the hospital."

### Blank Authentication Unnecessary

A final conclusion and recommendation made by the OSMA committee which received Council endorsement read as follows:

"**It was the committee's recommendation that, inasmuch as the Joint Commission has held that a single signature of the attending physician on the face sheet or summary of the medical record does not suffice to authenticate the entire content of the record, blanket authentication clauses may be eliminated from such forms, at the discretion of the hospital.**"

# AMPAC Wants You as a Member...

## Letter About American Medical Political Action Committee To Be Sent Soon To Ohio Physicians

WITHIN the next several weeks Ohio physicians will receive from Chicago, a letter asking them to affiliate with the American Medical Political Action Committee on either an active or associate membership basis ($10.00) or on a sustaining membership basis ($99.00).

The primary and immediate target of AMPAC is to get itself firmly and adequately established on a national basis. No state medical political action committee has been formed in Ohio. Whether one will be organized to serve as AMPAC's state unit will depend on political developments within Ohio. Those who believe in the idea should contribute now to AMPAC — not wait to see what happens in Ohio.

At its meeting December 16-17, The Council of the Ohio State Medical Association adopted the following resolution endorsing AMPAC:

### Endorsement Resolution

WHEREAS, Through the impetus of the American Medical Association, a voluntary, nonprofit, unincorporated organization known as the American Medical Political Action Committee has been established with headquarters at 520 North Michigan Avenue, Chicago, and

WHEREAS, The purposes of AMPAC are:

(a) To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.

(b) To encourage physicians and others to understand the nature and actions of their government, as to important political issues, and as to the records, officeholders and candidates for elective office.

(c) To assist physicians and others in organizing themselves for more effective political action and in carrying out their civic responsibilities.

(d) To do any and all things necessary or desirable for the attainment of the purposes stated above.

WHEREAS, Membership in AMPAC is open to licensed doctors of medicine, their spouses, members of their immediate family and employees of nonprofit medical societies or associations, active and associate membership dues being $10 and sustaining membership dues being $99, annually, therefore

BE IT RESOLVED, That The Council of the Ohio State Medical Association:

(1) Endorses the formation and purposes of the American Medical Political Action Committee;

(2) Urges members of the Ohio State Medical Association and members of their family, when called upon to assist in financing AMPAC, to do so by becoming a member of AMPAC or by making a voluntary financial contribution;

(3) Requests members of the Ohio State Medical Association to actively support and cooperate with AMPAC in furthering its educational activities and other objectives.

### Answers Are Here

Following are some questions and answers which provide pertinent information about the American Medical Political Action Committee, its purposes and objectives, who directs it, etc.

**What is AMPAC?**

The American Medical Political Action Committee is a voluntary, nonprofit, unincorporated group whose membership consists of physicians, their wives, the members of their immediate family, and others.

**Why was AMPAC organized?**

To meet an unmet need — the need of providing the medical profession with an opportunity to assume a more active and effective role in public affairs. AMPAC's dual role is (a) to help its members understand political issues; and (b) to organize them as an effective political action group.

**Is AMPAC affiliated with either major political party?**

No. It is not bound by Democratic or Republican party labels. The program and platform of the individual candidate will determine whom AMPAC supports — not the candidate's party affiliation.

**Who directs AMPAC's activities?**

A seven man Board of Directors, including six physicians and one member representing the Woman's Auxiliary to the AMA. No member of AMPAC's Board may serve for more than five years.

**Is AMPAC a permanent organization?**

Yes. AMPAC's members are profoundly interested in making their organization an effective, year-in-and-year-out operation. Experience has demonstrated that one-shot, one-issue membership programs for political education and action accomplish little.

**What is the relationship between AMPAC and the AMA?**

AMPAC will function independently of all medical organizations and societies — national, state, and local. However, the directors of AMPAC are appointed yearly by the Board of Trustees of the American Medical Association.

**Will AMPAC's educational and political activity duplicate, or work at cross purposes with, the**

activities of similarly oriented political action organizations?

No. As a national organization, AMPAC will supplement — not supplant — the programs now being carried out by such organizations. AMPAC's members should remain active in the political party of their choice. AMPAC simply furnishes the means whereby they can increase their political effectiveness substantially through combined effort.

**How will AMPAC use its financial resources to best effect?**

In three ways. First, through education. Depending upon the funds available. AMPAC will develop and promote such programs as: analyses of voting records; reviews of national legislative issues; voter registration drives; and publication of related materials and information.

Second, AMPAC will follow proven patterns of campaign activity. Selection of target areas will be based upon thorough analysis at the local level, review of reliable national analyses, the marginal nature of the specific district, and other pertinent factors. Support for candidates will be based upon realistic political appraisal.

Third, AMPAC will coordinate its efforts with the efforts of those individuals and groups — medical and nonmedical — who are actively engaged in programs designed to obtain good government.

**How can you and members of your family join AMPAC?**

By sending funds to AMPAC's Chicago Office, 520 N. Michigan Avenue, Chicago 11. Memberships are as indicated in the first paragraph of this article.

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## New Rule Issued on Filling of Prescriptions Adopted

The following regulation, Regulation 601, to the Ohio Sanitary Code, was adopted by the Ohio Public Health Council on December 16 and became effective January 1, 1962:

"No pharmacist shall sell or dispense a drug of a different brand than that prescribed by a physician, dentist, veterinarian, or podiatrist unless he shall have first obtained a written or oral authorization from such practitioner. If authorization is obtained the brand name or the name of the manufacturer of the drug dispensed must be stated on the prescription by the pharmacist. Where the prescription is written using a generic name the brand name or name of the manufacturer of the drug dispensed must be stated on the prescription by the pharmacist.

"Where prescriptions, written in medical records in a hospital, are filled from the regular floor stock of drugs, the person responsible for the hospital pharmacy or drug room must be able to determine the brand name or name of the manufacturer of such drugs."

## Sabin Answers Two Important Polio Vaccine Queries

County Medical Societies, as well as individual physicians, contemplating polio immunization programs on a community-wide basis or among individual patients, will find answers to two pertinent questions in a statement by Dr. Albert B. Sabin published in the December 2, 1961, issue of *The Journal of the AMA.*

The questions: How many injections of poliomyelitis vaccine are required for immunity? What are the advantages of the oral vaccine?

The answers: By Dr. Sabin in the following statement:

"Four doses of formalin-inactivated vaccine are recommended for those who received their first dose at 6 months or later and 5 doses for infants whose immunization is initiated before they are 6 months. In its 1961 report, the American Academy of Pediatrics committee on the control of infectious diseases also recommended a biennial booster dose.

"In community-wide programs during the winter and spring months, the oral vaccine is given in 3 doses, because each dose is designed to protect against one of the 3 types of poliovirus. For immunization of infants, as part of their regular medical care in their first year of life, a fourth dose consisting of all 3 types was recommended to make up for any possible interference with proper multiplication of any of the 3 types that might have been given in the hot months of the year, when the incidence of other enteric viruses is higher.

"The oral vaccine has the advantages that (1) it does not require injection; (2) it produces resistance to reinfection of the intestinal tract as well as antibodies in the blood; (3) immunity develops within one week after feeding any one of the 3 types; (4) community-wide programs are easier to perform, and when 70 per cent or more of the youngest children are quickly vaccinated the chain of transmission of polioviruses is broken, thereby protecting also those susceptibles in the family and community who remain unvaccinated; (5) a certain proportion of unvaccinated persons become immunized by intimate contact with very young, vaccinated children; (6) it is effective in aborting an epidemic, because it produces immunity rapidly and because it can be quickly administered on a mass scale, it also rapidly interferes with the implantation and spread of the epidemic poliovirus; (7) the immunity is more durable, and (8) it can be stored in a frozen state for many years without losing its potency."

---

In the first nine months of 1961, polio victims received more than $4.3 million in benefits from insurance companies under the provisions of special polio expense policies, the Health Insurance Institute reports.

# Deadline for Submission of Resolutions to Columbus Office of Association Is March 15

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions considered by the House of Delegates at the 1962 session in Columbus should heed the date March 15 and comply with the following:

1. Resolutions must be introduced at the First Session of the House of Delegates. The first session at the 1962 Annual Meeting, Neil House, Columbus, will be on Monday evening, May 14, starting with a dinner at 6 o'clock.

2. A resolution must be introduced in triplicate by a delegate or a duly accredited alternate who has been seated as a delegate due to the absence of a delegate. This must be done even though the resolution may have been published in *The Journal* or sent in writing to all delegates prior to the meeting.

3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least sixty (60) days prior to the first session of the House of Delegates. This requirement may be waived by a vote of at least two-thirds of the House of Delegates present at the first session.

4. To comply with the foregoing Constitutional provision on introduction of resolutions, resolutions for the 1962 Annual Meeting must be in the hands of the Executive Secretary on or before MARCH 15.

5. Resolutions received will be published in *The Journal* prior to the meeting and copies will be distributed in advance of the meeting to members of the House of Delegates to give them an opportunity to discuss resolutions with their constituents and possibly to receive voting instructions from their County Medical Society.

## Two New Birth Defects Centers Are Opened

Two new birth defects special treatment centers have been opened in Ohio by the National Foundation, supported by the March of Dimes.

One is located at Columbus Children's Hospital; the other at Cleveland Metropolitan Hospital. The former will focus its attention on molecular diseases. The center in Cleveland will emphasize care of multiple crippling congenital malformations. Director of the Columbus center is Dr. W. O. Robertson. Dr. William Clem is director of the Cleveland center.

These centers will provide, at the request of the attending family physician, diagnostic consultation, laboratory assessment, and suggestions for long-term management. Funds are available to help defray, when necessary, the costs of hospitalization, laboratory tests and medications.

The Columbus program is an extension of the birth defects clinic study center, established at Children's Hospital two years ago by National Foundation funds. More than 200 children have been seen to date by that clinic. Now similar specialized services will be offered to other groups of children with congenital abnormalities.

## Hospital Bed Increase in U. S. Behind Population Growth

The number of hospital beds in the U. S. has increased considerably since early in the century, but since 1946 the increase has not been as fast as that for the total population, Health Information Foundation reports. Although the number of beds per 1,000 population increased sharply during World War II, it later decreased and today is at about the same level as in 1940, some 20 years ago.

In the current issue of its monthly statistical bulletin, *Progress in Health Services*, the Foundation shows that the World War II peak of over 1,700,000 hospital beds corresponded to about 13 beds per 1,000 population. By 1960, the total was 1,658,000 beds in 6,876 hospitals listed by the American Hospital Association, or 9.2 beds per thousand population.

## Chicago Trauma Program

The sixth Postgraduate Course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons will be held April 25-28 at the John B. Murphy Memorial Auditorium, 50 E. Erie Street, Chicago. Details may be obtained by writing to Dr. John J. Fahey, committee chairman, 1791 W. Howard Street, Chicago 26, Ill.

# Ohio Specialty Groups To Meet At Time of OSMA Meeting

## Nine To Gather in Columbus, Week of May 14-18

ANOTHER outstanding innovation of the 1962 Annual Meeting of the Ohio State Medical Association will be meetings of nine medical specialty organizations during the week of the OSMA meeting in Columbus, May 14 - 18. This has resulted from conferences between officials of the Ohio State Medical Association, officials of the various specialty groups and officers of the Scientific Sections of the OSMA.

Outstanding programs will be presented jointly by the specialty societies and the OSMA sections. Meetings of the specialty societies for transaction of business or for social events are being arranged by the specialty groups at a time not in conflict with the scientific assembly which they will co-sponsor with the OSMA.

### THESE SPECIALTY GROUPS WILL MEET



Ohio Society of Internal Medicine
Ohio Psychiatric Association
Ohio Neurological Surgery Society
Ohio Chapter, American College of Chest Physicians
Ohio Ophthalmological Society
Ohio Society of Pathologists
Ohio Society of Physical Medicine
Ohio Orthopaedic Society
Ohio Chapter, American Academy of Pediatrics

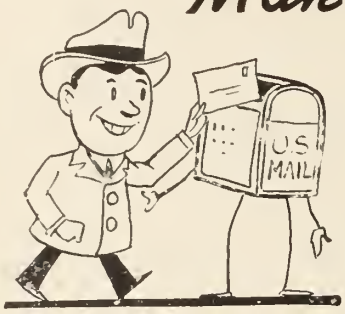


Another innovation at the 1962 meeting will be the presentation of addresses and panel discussions by members of the faculty of the Ohio State University College of Medicine at one of the General Sessions.

In addition, two splendid General Session scientific programs will be presented by the Ohio Chapter, American Cancer Society and the Ohio State Heart Association, as during the past several years at OSMA meetings.

The 1962 OSMA meeting will be an integrated meeting of the parent organization and the specialty societies; a state-wide get-together of general practitioners and specialists for postgraduate and refresher training.

# *Make Hotel Reservations Now!*




for the

## 1962 ANNUAL MEETING OF THE OHIO STATE MEDICAL ASSOCIATION

## May 14, 15, 16, 17, and 18

## COLUMBUS

*Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing*

| NAME AND LOCATION | SINGLE | DOUBLE | TWIN |
|---|---|---|---|
| NEIL HOUSE, 41 S. High St. (Headquarters Hotel) | $ 7.00- 9.50 | $ 9.50-12.00 | $12.00-15.00 |
| DESHLER HILTON HOTEL, W. Broad & N. High | $ 7.50-14.00 | $12.00-15.00 | $13.50-20.00 |
| PICK-FORT HAYES HOTEL, 31 W. Spring St. | $ 8.00- 9.50 | $11.00-12.00 | $14.00 up |
| HOTEL SOUTHERN, S. High & E. Main Sts. | $ 7.50- 8.00 | $10.00-10.50 | $11.00-12.50 |

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

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HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14-18, 1962, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Other

Arriving May.....at.....A. M.....P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

# APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1962 ANNUAL MEETING, VETERANS MEMORIAL BUILDING, COLUMBUS, OHIO, MAY 14-18

1. Title of Exhibit: _____

2. Name(s) of Exhibitor(s): _____

_____

Institution (if desired): _____

City _____

3. Do you have a built-in exhibit? _____

4. Description of Exhibit: **(Attach 200 word description to this blank)**

5. Exhibit will consist of the following: (Check which)

Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

Specimens _____ Moulages _____ Other material _____
(Describe)

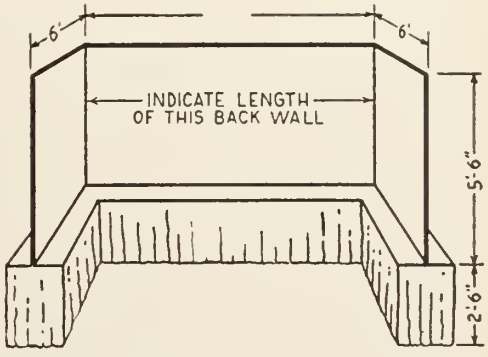
6. Booth Requirements:

Amount of wall space needed? _____

Back wall _____ Side walls _____

Square feet needed? _____

Shelf desired? (yes or no) _____




*Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.*

7. Transparency Cases:

Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____

_____

_____

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association."

Date _____

_____
Signature of Applicant

_____
Mailing Address, Street

_____
City, Zone, State

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO.
DEADLINE FOR FILING APPLICATIONS, FEBRUARY 15, 1962

# Athletic Injury Conference . . .

## Jointly Sponsored Eastern Ohio Program Brings Together Ohio High School Coaches, School Officials and Physicians

COACHES, team physicians, administrators and trainers from 27 high schools participated in the Eastern Ohio Area Athletic Injury Conference held December 13 at the New Philadelphia High School Auditorium.

The conference was sponsored by the Tuscarawas County Medical Society, Tuscarawas County Schools, and the New Philadelphia and Dover High Schools, with the cooperation of the Joint Advisory Committee on Athletic Injuries of the Ohio State Medical Association and the Ohio High School Athletic Association.

W. E. Laws, Tuscarawas County Superintendent of Schools, and a former member of the Board of Control of the Ohio High School Athletic Association, opened the conference with a history of the joint efforts of the OSMA and the High School Athletic Association in the injury prevention field.

Presiding throughout the meeting and serving as moderator for a problems clinic on athletic injuries at its close was Dr. Robert E. Rinderknecht, Dover, president of the Tuscarawas County Medical Society.

Introduced for remarks were Paul E. Landis, OHSAA Assistant Commissioner; Leon S. Force, New Philadelphia High School Superintendent, who was host to the meeting; and Hart F. Page, OSMA assistant director of Public Relations, and a member of the Joint Committee in charge of arrangements.

Speaking on "Medical Qualifications for High School Athletics," Dr. Thomas E. Shaffer of Columbus, a member of the OSMA Committee on School Health, pointed out the importance of proper medical examination of all athletes and urged that all have proper immunizations before participating in high school sports. He described the relationship of physical maturity to effective performance in athletics and outlined a physical fitness index test which may be utilized to determine the extent to which an athlete is conditioned.

Dr. Robert J. Murphy of Columbus, chairman of the OSMA-OHSAA Joint Committee, spoke on the recognition and referral aspects of injuries. He said that a physician should be present at all high school football games, and that whenever possible high schools should have team physicians. Discussing the use of drugs and stimulants, he was of the opinion that they are not helpful, and may in fact be harmful. "No medicine or drug in the world will make a poor tackler a good one or a poor passer outstanding," he said.

Dr. Murphy strongly endorsed physical condition-





*Scenes at the Eastern Ohio Area Athletic Injury Conference.*

*Left: Problems Clinic on athletic injuries, left to right, Dr. Shaffer; Dr. Rinderknecht, panel moderator; Dr. Murphy and Mr. Biggs, shown as they answered questions from the audience.*

*Right: Informal discussion at the close of the meeting. Far left, Tuscarawas County School Superintendent W. E. Laws chats with New Philadelphia Superintendent Leon S. Force, and Assistant Athletic Commissioner Paul Landis (back to camera). On stage, Ernest Biggs finishes a taping demonstration.*

ing for all athletes before and during each season. He recommended running as the best conditioning exercise.

The third speaker, Ernest R. Biggs, head trainer for the Ohio State University since 1942, said that it is vital to prevent injuries by the use of the right



*A section of the audience at the Eastern Ohio Area Conference attended by coaches, team physicians, trainers and administrators from 27 high schools.*

equipment, the proper taping of ankles and knees, and the conditioning of all athletes. Trainer Biggs demonstrated various taping procedures and showed the participants the recent developments in protective equipment, especially the OSU football helmet, which along with special exercises, has impressively decreased head and neck injuries at Ohio State during the past year.

## Cincinnati Area Physicians and Hospitals Adopt Joint Policy

The Greater Cincinnati Hospital Council and the Council of the Academy of Medicine of Cincinnati have jointly adopted the following policies: (1) "Patients having Blue Cross and Blue Shield coverage or the equivalent, are to be considered as private patients." (2) "To further total hospital bed usage, it is recommended that the hospitals and the hospital staff afford privileges to any qualified physician. Qualified physicians shall be those physicians who are members of the Academy of Medicine, or eligible for membership, whose qualifications have been received and accepted by qualifying boards of each respective hospital." These policies will be implemented to give patients a free choice of hospital beds. The latter policy does not pertain to membership on a particular staff or staff privileges.

### Miss Jamieson Dead

Miss Mary A. Jamieson, 88, Ohio Hospital Association President in 1932-33, died in Glouster, New Jersey, November 5. Miss Jamieson was superintendent of Grant Hospital, Columbus, Ohio from 1914 - 1933, and organized the hospital section of the Industrial Commission of Ohio.

## Medical Plan for Coal Miners Started

Following are excerpts from an article published December 5, 1961, in the Martins Ferry *Times-Leader* relating to the formation of a medical care plan under a law enacted by the Ohio Legislature in 1959, authorizing the formation of corporations to engage in consumer controlled medical care plans:

"The Medical Foundation of Bellaire today announced the creation of a home and office medical care plan available to coal miners and their families.

The plan is designed as a supplement to benefits miners already receive from the United Mine Workers Welfare and Retirement Fund. Subscribers will prepay by checkoff for such things as office visits, home calls, shots, certain drugs, office treatments and health examinations.

A spokesman for the Medical Foundation said 650 miners in the Cadiz-Adena area members of Local 7690, have been invited to participate. He indicated that as soon as arrangements can be worked out with other UMW locals in the immediate area, other miners will be asked to join.

Under the plan, each subscriber becomes a member of the Foundation and is entitled to a vote for trustees.

The Foundation spokesman said the plan is designed to be combined with the Welfare Fund benefits to give the miner and his family more comprehensive medical coverage. He emphasized it does not include services already provided by the Welfare Fund.

The cost of the program runs from $5 per month for a coal miner and family down to $1 monthly for widows and dependents.

Subscribers to the plan will receive treatment at one of the three clinics owned by the Foundation: Harrisville, Bellaire and Powhatan. The Clinics are rented to a medical group whose physicians will provide the medical services.

To be eligible to participate, miners must be members of a UMWA local union. Unemployed miners are also eligible if they were subscribers 30 days prior to unemployment and remain eligible at $1 per month for a year or until employed elsewhere. Widows gain eligibility only if the husband was a subscriber prior to his death.

### Western Reserve Grant

A grant of $3,388,706 for the establishment of a clinical heart research center at Western Reserve University has been made by the National Institutes of Health of the United States Public Health Service.

Dr. Walter H. Pritchard, professor of medicine, and Dr. Simon Koletsky, professor of pathology, in the WRU school of medicine, have been named co-directors of the center.

The grant will be paid in annual installments over a seven-year period.—*Cleveland Plain Dealer.*

# AHA Advocates New Plan...

## Hospital Association Asks for National Blue Cross Program. With Federal Aid. in Lieu of the King Bill

A NEW POLICY on the question of health services for persons 65 and over was adopted by the House of Delegates of the American Hospital Association at a special meeting in Chicago the first week in January.

The action expressed continued opposition to H. R. 4222, the King-Anderson bill, but advocated a plan partially subsidized by the Federal Government to provide hospital care under a national Blue Cross program.

### AMA Comment Brief

**No statement had been issued up to press time by the AMA regarding the AHA action except one expressing gratification that the AHA had continued its opposition to H. R. 4222. Apparently the Board of Trustees of the AMA is planning to make no additional statements until more details of the hospital association proposal are available and, perhaps, a draft copy of proposed legislation has been prepared.**

Following is the text of the official statement adopted by the American Hospital Association House of Delegates, including two parenthical paragraphs, transmitted from Chicago to the AHA Washington office, over the signature of Dr. Edwin L. Crosby, Executive Vice-President of AHA:

### Text of Statement

1. We reaffirm the crucial need to continue vigorous efforts to foster realistic and equitable programs in every state for the adequate health protection of the indigent and medically indigent under a mechanism similar to the Kerr-Mills Act."

[It was understood that to improve the effectiveness of state programs under the Kerr-Mills Act, more attention must be placed on adequate reimbursements to participating hospitals and other health care institutions.]

"2. We recommend the earliest possible implementation of a national Blue Cross program for a voluntary, nonprofit plan available to all persons aged 65 and over.

"3. We recognize that government assistance is necessary to effectively implement this national Blue Cross proposal in order to enable many retired aged persons to purchase this health protection through the voluntary prepayment system. Conditional upon the administration of this proposed plan by the voluntary nonprofit prepayment system, the tax source of the funds is of secondary importance to us."

[The last sentence of the above statement was interpreted to mean that the source of funds is of secondary importance to us provided the proposed plan is administered by the voluntary nonprofit prepayment system and not by the Social Security Administration.]

"4. The individual aged person should receive governmental financial assistance on a decreasing scale related to income, the low income person to receive major, or even total assistance, and the higher income person to receive less. The determination for government assistance should be made in accordance with current income reported for Federal income tax purposes or, if this is not possible, some legally acceptable declaration of income. The determination should not be made in accordance with the usual means test determinations made under public welfare programs.

"5. We emphasize the urgency and importance of planning for the provision of adequate facilities and personnel in order that skills and services may be available to render high quality care to the aged.

"6. It is the sense of this meeting of the House of Delegates of the American Hospital Association that the best interests of the retired aged will not be served by passage of the King-Anderson bill. Our opposition to this bill is based upon careful study of the needs of the retired aged and the over-all economic effect of such a program. We believe that the retired aged will be better served by a program such as has been proposed by Blue Cross Plans."

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### Holds "Fly-In" Disaster Drill

Members of the Flying Physicians Association from five states responded to an "emergency call" for assistance in a mock disaster designed by Cincinnati CD authorities to test the FPA's readiness. Approximately 45 physician-pilots from Ohio, Indiana, Kentucky, Pennsylvania, and New York flew in to Cincinnati's Lunken Airport. Upon landing, they were taken to a 200-bed CD Emergency Hospital to treat the "casualties," composed of members of several local military reserve units. Civil Defense officials termed the exercise one of the most successful ever held.

NEW B.I.D. DOSAGE




# PRO-BANTHĪNE P.A.®

(BRAND OF PROPANTHELINE BROMIDE)

## PROLONGED-ACTING TABLETS—30 mg.

## Effective • Convenient • Sustained Action

PRO-BANTHĪNE®, the leading anticholinergic, is now available in a distinctive prolonged-acting dosage form.

The prolonged action of new PRO-BANTHĪNE P.A. is regulated by simple physical solubility. Each PRO-BANTHĪNE P.A. tablet releases about half of its 30 mg. promptly to establish the usual therapeutic dosage level. The remainder is released at a rate designed to compensate for the metabolic inactivation of earlier increments.

This regulated therapeutic continuity maintains the dependable anticholinergic activity of PRO-BANTHĪNE all day and all night with only two tablets daily in most patients.

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# Medical Board Examinations...

## Sixty-Eight Doctors of Medicine Apply for Licenses: Questions Given in December Examinations Listed

THE State Medical Board gave examinations to 68 graduates of schools of medicine who are seeking licenses to practice in Ohio, December 18-20 in Columbus, it was reported by Dr. H. M. Platter, secretary of the Board. Applicants included 19 graduates of U. S. and Canadian medical schools and 49 graduates of foreign schools. The Board also examined 28 persons who are seeking to practice osteopathic medicine and surgery.

In the limited practice branches, the Board gave examinations to the following number of persons: Mechanotherapists, 8; chiropractors, 39; masseurs, 13; cosmetic therapists, 6; physical therapists, 5.

Results of the examinations were scheduled to be announced following a meeting of the Board on January 30.

Following are questions given to applicants for licenses to practice medicine and surgery:

### Anatomy

1. Name the retroperitoneal structures in the abdomen.
2. What nerves are involved in the following conditions? (a) Bell's palsy; (b) wrist drop; (c) footdrop; (d) paralysis of external rectus muscle; (e) tic douloureux.
3. Name the important foramina in the posterior cranial fossa and the structures that pass through them.
4. Name the muscles of mastication.
5. Label a diagram of the eye.
6. Name the important structures which lie at the level of the angle of Louis.
7. Name the structures which make up the spermatic cord.
8. Name the ligaments of the knee joint.
9. Label a diagram of the skin of the sole of the foot.
10. Draw the normal curves of the spine.

### Physiology

1. (a) What structures are innervated by the autonomic nervous system? (b) What structures are innervated by the somatic nerves? (c) How do these two divisions of the peripheral nervous system differ anatomically?
2. (a) What do you understand are the adrenocortical principles (adrenal corticoids)? (b) Name two and give their physiological function.
3. (a) What is the physiological action of heparin? (b) What is its chief use in medical practice?
4. Describe by illustration the interrelation between the hypothalmus, pituitary and the target endocrine organs.
5. Classify the hormones of the adrenohypophysis.
6. (a) What is the physiological action of adrenocorticotropic hormone (ACTH, corticotropin)? (b) How is it used in determining the functional integrity of the adrenal cortex (Thorn test)?
7. (a) Name some of the undesirable hormonal effects (side-effects) following prolonged use of corticotropin. (b) Name five contraindications for its use. (c) What precautionary tests and observations should be made in the prolonged therapeutic use of this medication?
8. (a) Name and briefly describe four methods of demonstrating vestibular nystagmus. (b) How can you objectively differentiate between ocular and vestibular nystagmus?
9. Sketch and label the visual pathways.
10. (a) What are isotopes? (b) How are the unstable isotopes of value in determining the physiological function of certain body functions and pathology?

### Bacteriology

1. In what ways can the diagnosis of Typhoid be made? (a) What is the carbohydrate media change that differentiates the Salmonella Typhosa from the more common members of the group, formerly known as the paratyphoid bacilli?
2. Which of the common bacteria listed causes "food poisoning"? (a) Clostridium Botulinum. (b) Staphylococcus. (c) Salmonella. (d) Streptococcus Faecalis. (e) Bacillus Cereus. (f) Clostridium Perfringens.
3. What fungus disease produces findings similar to Tuberculosis? (a) What is it caused by?
4. Name five etiologic agents which result in Non Suppurative Meningitis (Aseptic Meningitis).
5. Name three illnesses caused by the Coxsackie Virus.

### Diagnosis

1. Differentiate between joint pains of subacute rheumatic fever, gout and osteoarthritis.
2. What are the complications of dislocation of the hip?
3. Describe Horner's syndrome.
4. Differentiate bronchiogenic cysts from cysts of the thyroglossal duct.
5. Give the symptoms, signs and diagnosis of hyperparathyroidism.
6. Define the various kinds of luxation.
7. Enumerate the diseases of the spine that will increase the alkaline phosphatase.
8. Differentiate simple schizophrenia from catatonic schizophrenia.
9. Give the differential diagnosis of tabes dorsalis and nucleosis pulposis (disc).
10. Of what clinical significance is the finding of enlargement of Virchow's gland (sentinel node) which drains the thoracic duct?

### Chemistry

1. List the causes of hypoglycemia.
2. Given a jaundiced patient (adult), outline the laboratory tests you feel would contribute to a differential diagnosis between intrahepatic and posthepatic, causes, give reasoning.
3. Indicate briefly the clinical significance of each of the following: (a) A positive heterophile agglutination test. (b) A High Blood alkaline phosphatase. (c) A High Blood acid phosphatase.
4. Define the following: (a) Methemoglobin. (b) Thyroglobulin. (c) Nitrogen balance. (d) Intrinsic Factor.
5. List the significant laboratory findings in acute glomerulonephritis.

### Materia Medica and Therapeutics

1. What is meant by autonomic blockade? Give example of each action.

*(Continued on Page 206)*



For seven years SIGMAGEN has been successfully used in the treatment of bursitis and myositis. SIGMAGEN provides a conservative, in-between level of therapy — far more capable than analgesics, yet not approaching high steroid dosage levels.

SIGMAGEN will swiftly allay the pain and quiet the inflammatory process in mild rheumatoid arthritis, bursitis, myositis and fibrositis.

# Bursitis and myositis respond to Sigmagen®

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| Acetylsalicylic acid/ for anti-inflammatory-analgesic action | 325 mg. |
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For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, New Jersey.

**Bibliography:** 1. Cohen, A., et al.: J.A.M.A. 165:225, 1957. 2. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 3. Moravec, C. L. and Moravec, M. E.: Clin. Med. 7:2322, 1960. H-416

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(Continued from Page 204)

2. Give the mille-equivalents of sodium, potassium and chloride to satisfy daily requirements at basal level.
3. Give the mechanism of action of three antithyroid agents.
4. Give the prophylaxis and treatment of infusion reactions.
5. Outline the treatment of decompression illness (cassion's disease or Aeroembolism).
6. What are the modern concepts in the treatment of acute myelogenous leukemia?
7. Give the treatment of Pancreatic Cystic Fibrosis.
8. Outline the treatment of a patient 70 years of age with arteriosclerotic heart disease.
9. Outline the causes and treatment of insomnia.
10. You are the attending physician of a terminal cancer patient and you are going to be absent from your practice for a period of two weeks. What are your obligations to the patient?

## Practice

1. Give the etiology of subacute bacterial endocarditis. What are the signs, symptoms, treatment and prognosis?
2. Differentiate infectious Mononucleosis from Leukemia. How would you make the diagnosis? Give the treatment.
3. Discuss the etiology of bronchial asthma. Give the differential diagnosis and treatment.
4. Outline the management of a patient you are called on to see with carbon monoxide poisoning.
5. Give the cause and management of a patient with splenomegaly.
6. Differentiate Cerebral Hemorrhage and Cerebral Thrombosis and give treatment you would prescribe for each.
7. What are the early symptoms of Typhoid Fever? How would you make a diagnosis and give the treatment.
8. Give the etiology, pathology and symptoms of a peptic ulcer. How would you manage such a case medically?
9. A patient comes to your office complaining of pain, swelling and some loss of motion in a knee. How would you make a diagnosis and what is your treatment?
10. Give the symptoms and the treatment of angina and differentiate it from acute coronary occlusion.

## Pathology

1. Define granulomatous inflammation. (b) Name two types.
2. Name three impairments in which infarction of the kidney most commonly occurs.
3. List the usual gross autopsy findings of subacute bacterial endocarditis.
4. Name two tissues with little or no capacity for regeneration.
5. Indicate one characteristic pathologic lesion found in each of the following diseases: (a) typhus, (b) poliomyelitis, (c) influenza, (d) mumps, (e) rabies.
6. Indicate a pathologic lesion that may be caused by each of the following chemicals: (a) carbon monoxide, (b) lead, (c) sulfonamide, (d) fluorine.
7. List two complications that may develop following myocardial infarction.
8. What is the most characteristic microscopic finding that aids the pathologist to make a diagnosis of: (a) Squamous cell carcinoma, (b) Rhabdomyosarcoma, (c) Hodgkin's disease, (d) Mixed tumor of parotid.
9. In hypersplenism certain factors of the blood may be excessively destroyed. Indicate the name of the disease entity in each use [when the factor destroyed is]: (1) circulating red cells; (2) platelets; (3) neutrophilic leukocytes.
10. Indicate three alterations that one might find in an autopsy on a patient who has died in uremic coma.

## Surgery

1. At what age would you advise each of the following defects be surgically corrected? (a) pyloric stenosis, (b) syndactylism (webbed fingers), (c) imperforate anus, (d) Inguinal hernia, (e) hemangioma of the scalp.
2. Following a cholecystectomy and exploration of the common bile duct, a T-tube was placed in the common duct. (a) How do you determine when the T-tube can be removed? (b) Suppose a stone is found during these studies, what would you advise be done? (c) What would you tell the patient?
3. (a) What part of the colon is most frequently the site of carcinoma? (b) What are the usual symptoms from a tumor in this area? (c) What diagnostic measures should be carried out? (d) What type of surgical procedure would you advise? (e) What would you tell the patient about the problem and the prognosis?
4. A patient has sustained a laceration while working out of doors and protection against tetanus infection is indicated. There is a history of serum sensitivity and there has been no previous immunization with tetanus toxoid. (a) How would you test for sensitivity to antitetanus serum? (b) If sensitive, outline a procedure for desensitizing the patient, and administering a prophylactic dose. (c) What other preparation might be used? (serum) (d) What else might be done at the time of the treatment if the patient is markedly allergic and no other serum is available?
5. Briefly outline the treatment for fracture of both bones on the forearm, in the lower one-third (1/3).
6. A 75 year old man is found to have enlargement of the prostate, obstructive symptoms, and requires immediate attention. (a) What laboratory tests would you order? (b) What X-Rays would you order? (c) What urological procedures should be carried out? (d) What surgery would you advise? (e) What prophylactic surgery should usually be done before the actual prostatic procedure?
7. Briefly (as few words as possible) define each of the following: (a) polydactylism, (b) club foot, (c) genu valgum, (d) genu recurvatum, (e) Hallux valgus.
8. A patient developed atelectasis of the right lung postoperatively. In three separate columns, list signs, symptoms, treatment.
9. A 7 year old child, riding a wooden hobby horse, falls to the floor, the horse falling upon her. Her only complaint subsequently is abdominal pain. (a) What is the most probable diagnosis? (b) What laboratory tests and studies would be helpful? (c) How soon would you operate, and what would you do?
10. A patient is to undergo gastrectomy for benign pathology. In separate columns, (a) List 5 pertinent and necessary pre-operative orders. (b) List 5 pertinent postoperative orders.

## Obstetrics and Gynecology

1. Describe what takes place in the normal third stage of labor.
2. Name the different types of abortions.
3. Give briefly the management of a case of prolapse of the cord.
4. Give the types of versions and the method of performing each type.
5. Name four laboratory tests which should be done on the day a new pregnancy case is first examined in the office.
6. A 35 year old woman who had onset of menstruation at the age of 12 years, a cycle of 28 days average, and menstrual duration of 5-7 days, usually experienced cramps the first day or two of each period. For the past year she has had increasingly severe cramps now persisting throughout the period, and frequently thereafter, a sensation of fullness in the pelvis, tenderness of the uterus, low backache, and dyspareunia. (a) What is the most likely diagnosis? (b) What medical (nonsurgical) program might be tried to relieve her? (c) If surgery is indicated, what would you advise?
7. Give the signs, symptoms and treatment of monilia vaginitis.
8. A 38 year old woman during routine physical examination had PAP smears taken of the cervix and endocervix, and submitted to the laboratory for study. These smears were read as Class III. (a) What is a PAP smear? (b) What is meant by a Class III reading? (c) What procedures are now indicated? (d) Do you recommend routine smears on women? and (e) If so, what criteria would you establish?
9. A 68 year old patient complains of weakness, pelvis fullness and pressure, and occasional blood tinged vaginal discharge. Examination reveals a pleural ef-

(Continued on Page 208)




"cramps" don't cramp her style...

when you prescribe

**Trancoprin®**

Aspirin.....(5 grains) 300 mg.
Trancopal® (brand of chlormezanone).....50 mg.

**Trancoprin is more than a simple analgesic:** It deals with cramping pains in three ways. Besides dimming pain perception, Trancoprin, through its tranquilizing action, reduces anxiety and raises the tolerance for discomfort. And, against the spasm caused by pain which, in turn, produces more pain, Trancoprin exerts its skeletal muscle relaxant action.

**Trancoprin is exceptionally safe to use:** Fewer than two and a half per cent of patients can be expected to have any side effects, and these are of a minor nature.

Available in bottles of 100 tablets. The usual dosage in dysmenorrhea is 2 tablets 3 or 4 times daily.

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*(Continued from Page 206)*

fusion on the left, marked anemia, and a pelvic mass. (a) What is the most probable diagnosis? (b) How would you treat the patient? (c) What is the prognosis?

10. A patient is found to have multiple nodules apparently arising from the uterus, and a diagnostic impression of fibroids is made. (a) Name three types of fibroids of the uterus. (By location) (b) Give three types of fibroid degeneration. (c) Give three symptoms frequently associated with fibroids. (d) What differential diagnostic measures would you recommend?

### Specialties

1. (a) Name the clinical manifestations of the "post mature Syndrome" in case of the newborn. (b) Outline the diagnosis and treatment of "sepsis of the newborn."
2. Describe briefly the lesions and treatment of the following skin disorders: (a) Seborrheic dermatitis of the scalp and skin, (b) Scabies, (c) Intertrigo, (d) Ritter's Disease.
3. What laboratory tests of the urine are indicated for the treatment of acute pyelonephritis? (b) What measures should be taken if there are repeated attacks of pyelonephritis? (c) In children, which sex is more often affected and why?
4. (a) Classify, as to etiology, chronic paranasal sinusitis. (b) Outline the symptoms of the two most common classes. (c) Outline the treatment and management of the two most common classes of chronic paranasal sinusitis.
5. (a) Define positional vertigo. (b) Outline the etiology of positional vertigo. (c) Outline the management of this condition.

### Preventive Medicine and Hygiene

1. Discuss undulant fever — its cause and prevention.
2. Discuss tinea capitis. How is it spread and how is it treated?
3. When properly protected, how long does immunity last in the following diseases: (a) smallpox, (b) polio, (c) scarlet fever, (d) tetanus, (e) typhoid fever.
4. Discuss infectious mononucleosis — its cause and treatment and complications.
5. What diseases are required to be reported to the local Board of Health?

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## Disability Insurance Protects Many

As of the end of 1960, insurance companies protected 31,836,000 persons against the loss of income due to disability, and 10,600,000 workers were protected by other arrangements such as formal paid sick leave plans of Federal, state and local governments; private industry; union plans, and employee mutual benefit associations, the Health Insurance Institute reports.

The total of 42,436,000 persons so protected — representing 60 per cent of the civilian labor force — did not include the millions of other employees with some degree of income protection through informal wage-continuation practices, said the Institute. In addition, workmen's compensation provides wage replacement and medical care benefits for workers who are disabled while on the job.

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The Department of Physiology at Ohio State University is sponsoring a series of Friday luncheon seminars at the Health Center. The series is an outgrowth of weekly intradepartmental luncheon meetings held for years by the physiology faculty.

# Do You Know? . . .

John H. Lawrence, M. D., director of Donner Laboratory & Donner Pavilion, University of California, Berkeley, Cal., will speak on "Radioactive Isotopes and Nuclear Radiations in Medicine" as the Henry B. Freiberg Lecturer, Tuesday, April 3, at the Jewish Hospital's Medical Auditorium, Cincinnati. The entire medical community is invited.

* * *

The 302nd Troop Carrier Wing (Reserve), Clinton County Air Force Base, Wilmington, Ohio, has a limited number of openings for flight surgeons.

* * *

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, has been named to an additional four-year term on the Ohio Advisory Council for Hospital and Medical Facilities Construction. This council consults with and advises the Hospital Facilities Office of the Ohio Department of Health.

* * *

Dr. Irvine H. Page, Cleveland, has been nominated for the John Phillips Memorial Award, one of three special awards to be presented at the annual session of the American College of Physicians in Philadelphia, April 9-15. Dr. Page will lecture on "The Changing Outlook for the Hypertensive."

* * *

New address of the Joint Blood Council, Inc., is 1500 Massachusetts Ave., N. W., Suite 832, Washington 5, D. C.

* * *

Four Ohio physicians were honored with the William Peck Research Award at the meeting in Cleveland of the Interstate Postgraduate Medical Association. They are Dr. John H. Wulsin, Cincinnati; Dr. David A. Taft, Columbus; Dr. John H. Davis, and Dr. Bernard R. Landau, both of Cleveland.

* * *

Governor Michael V. DiSalle has appointed Miss Ilean Moore, R. N., an instructor on the faculty of Springfield City Hospital School of Nursing, to the State Nurses Board, and has reappointed Miss Helen Massengale to the Advisory Council to the Board. At its December meeting, the Board re-elected Miss Laura Rosnagle, R. N., of Cincinnati, to serve as president, and Miss Carol Randall, R. N., of Cleveland, to serve as vice-president during 1962.

* * *

One of Chile's highest decorations, the Condecoracion Orden al Merite Bernardo O'Higgins, has been awarded to Dr. William F. Ashe, professor and chairman of the department of preventive medicine at Ohio State University, for his services to the Chilean government as chief of a U. S. Interdepartmental Committee on Nutrition for National Defense Mission, which surveyed the nutrition of the country in 1960.

# OMI Available To Small, As Well As Large, Groups

By R. DEAN DOOLEY, M. D.
Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

VOLUNTARY prepayment insurance has undeniably been our most effective tool in spreading and making medical care accessible to great masses of our population.

Ohio Medical Indemnity makes its contracts available without the diluting and confusing influence of pre-existing clauses, health statements, or physical examinations.

Underwriting controls are employed in the non-group, over the counter contracts by requiring waiting periods for stated procedures. These contracts can be purchased at anytime in most Blue Cross Areas.

There is no cancellation for excessive use, and no one is denied protection because of age or physical condition.

The Ohio Blue Shield Plan, operates as a community project, thereby enabling increasing numbers of people to secure health care through the pooling of community funds.

By this means, individuals in the lower economic bracket are able to obtain the same health care enjoyed by their more fortunate neighbors.

It is not generally known that O. M. I. has concentrated its efforts in the small groups as well as the large ones. A great volume of our subscribers come from small groups of five or more.

Subscribers from small groups may not be the most desirable from an insurance standpoint, yet, our failure to provide a prepayment mechanism in this segment of our population, where it is most needed, would be disastrous.

The direct-pay, over the counter, and retiree subscribers are vitally important in the light of our socio-economic responsibility. Until we can declare that no area of our population is denied the advantage of organized and planned means of meeting the cost of health care, the social planners have a ready excuse for entering the picture to correct the deficiency.

I cite the following case to exemplify the preceding remarks and dramatize the part O. M. I. is playing in helping its subscribers meet the cost of health care.

Here is a patient with stricture of the right ureter. Because of the nature of her illness, repeated treatments over a long period of time have been required to effect a cure. The initial claim for uretal catheterization and dilatation was submitted August 1, 1952, and since that time we have processed 52 other claims submitted for repeat dilatations. A total of $1,350.00 has been paid out to this subscriber over a period of eight years.

I do not know the economic status of this individual, but I believe it can be asserted that O. M. I. has eased the financial burden produced by her illness. This is the purpose of prepayment insurance, and it is the objective of O. M. I. to improve the effectiveness of its programs, so that adequate coverage may be available to all of Ohio's citizens.

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### Cincinnati Physician Is President-Elect Of American Rhinologic Society

Dr. Raymond L. Hilsinger, Cincinnati, assistant professor of otolaryngology, University of Cincinnati College of Medicine, has been named president-elect of the American Rhinologic Society, an international organization which has its headquarters at 530 Hawthorne Place, Chicago. He will succeed Dr. Charles J. Petrillo, of New Haven, Conn., as president next year. Dr. Hilsinger also is a member of the organization's research committee and is chairman of the program committee.

Dr. Harvey C. Gunderson, Toledo, is serving as regional director for the society. At the recent meeting, Dr. Stewart I. Adam, Dayton, was elected a new member.

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### Asks Supreme Court To Rule

Executive Committee of the Ohio State Bar Association has petitioned the Ohio Supreme Court to rule whether attorneys may form corporations for the practice of law under the provisions of Senate Bill 550 enacted by the Legislature in 1961 which authorizes the formation of corporations to carry on the practice of specified professions, including the medical and legal professions.

In Our Opinion

# Comments on Current Economic, Social And Professional Problems

### DESPERATION TACTICS ARE ALARMING

The political road show which was staged by the Kennedy cabinet members and camp followers recently in various parts of the country (one showing was in Cleveland) might well indicate that the administration is running scared in its drive to get Congress to enact certain pieces of legislation, including the tie-in of medical care to Social Security. Reports indicate that these "Little White House Conferences" were not held for the purpose of securing information from the grass roots but to propagandize for pet issues.

Congressman Tom Curtis of Missouri rang the warning bell when he proclaimed: "When the executive, in order to get through his programs, seeks to undermine the confidence of the people in the representative system of government by appealing to the people through propaganda instead of testimony at congressional hearings, the people should take immediate alarm."

Incidentally, the Cleveland Academy of Medicine is to be congratulated on the splendid job it did in seeing that well-versed and articulate persons represented medicine at the Cleveland session. Their participation gave those in attendance an opportunity to hear both sides of the questions discussed and in numerous instances, had a leavening effect. The academy had prepared for such an emergency. It's a lesson for other county medical societies.

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### WHO SAYS THE AMA ISN'T POSITIVE?

Who says the AMA is always on the negative side? The uninformed or misinformed, of course, as the facts will not support the charge.

Of the 555 health bills which were submitted to the Congress in 1960, the AMA opposed only three — the King Bill (H. R. 4222), the Kefauver drug bill and a measure on drug advertising.

During the 85th and 86th Congresses, the AMA presented statements on 71 bills, opposing only 12 of the total. Since 1957, the record is 80 statements submitted of which only 15 were negative.

Don't let an uninformed or misinformed patient or friend get away with loose talk about the AMA. After all, it's your AMA.

### CONFORM— OR ELSE, SAYS BOSS MAN

A recent Associated Press dispatch quoted HEW Secretary Ribicoff, commenting on proposed changes in the Federal-State public assistance program, as follows:

"If a state does not conform, then we cut off their money."

Inasmuch as no denial has been expressed by Mr. Ribicoff, to the best of our knowledge and belief, he merely must have been following the U. S. Supreme Court edict: "that which the government subsidizes it has a right to regulate."

Just thought we'd mention this in passing for the benefit of those who believe Uncle Sam is a beneficent Santa Claus.

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### PRODUCTION ONE THING; CONSUMPTION ANOTHER

We see by the papers that the Michigan State Medical Society has established a socio-economic department with a full-time economist in charge. Summing up the society's needs for qualified socio-economic advice, Dr. Otto K. Engelke, president of the society, stated: "Hospital administrators talk knowingly about medical care costs. So do government people and newspaper columnists. Our study will enable Michigan doctors to talk as knowingly on the subject as anybody in the country."

The idea sounds fine but we wonder how they are going to get the Michigan doctors, who are about like all others, to read the material which the new agency puts out. Hope they'll pass on the solution to this question, should they find it.

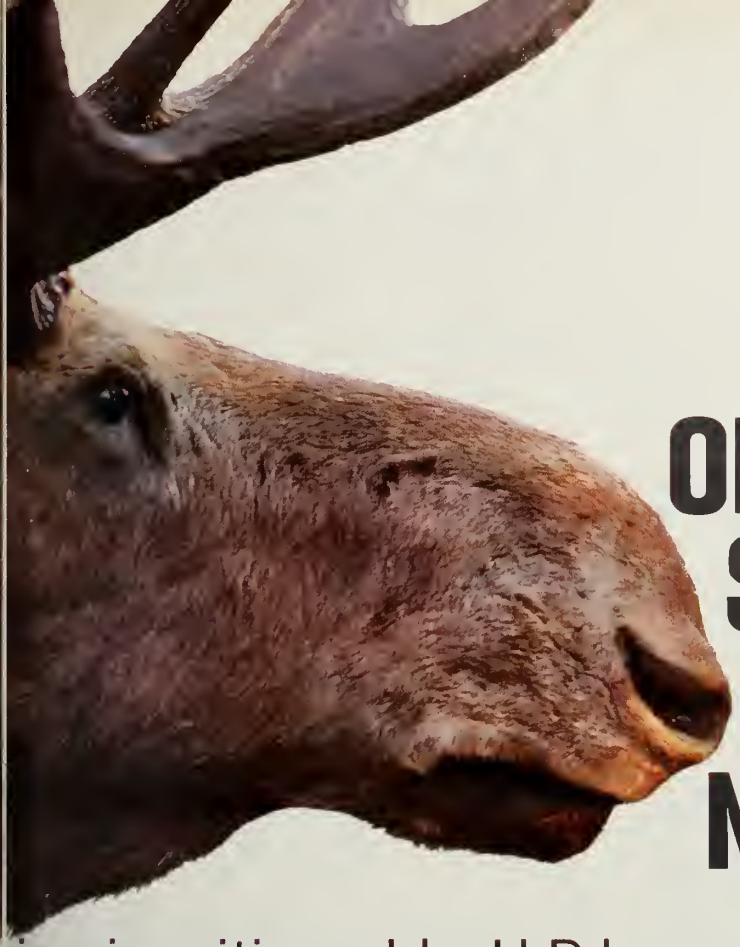
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### LEGAL DANGERS OF TRANSFUSIONS SHOULD NOT BE IGNORED

Some physicians tend to disregard the inherent dangers which accompany blood transfusions, the technique of which has become routine and commonplace. Let them beware, says Bernard D. Hirsh, director of the law department of the American Medical Association. Writing in *New Medical Materia* Hirsh sounds this warning which physicians should heed:

"The inherent dangers of blood transfusion must always be weighed by the physician against the possible benefits to the patient. The statistics of mortality are too ominous to be ignored — and the pos-

*(Continued on Page 214)*



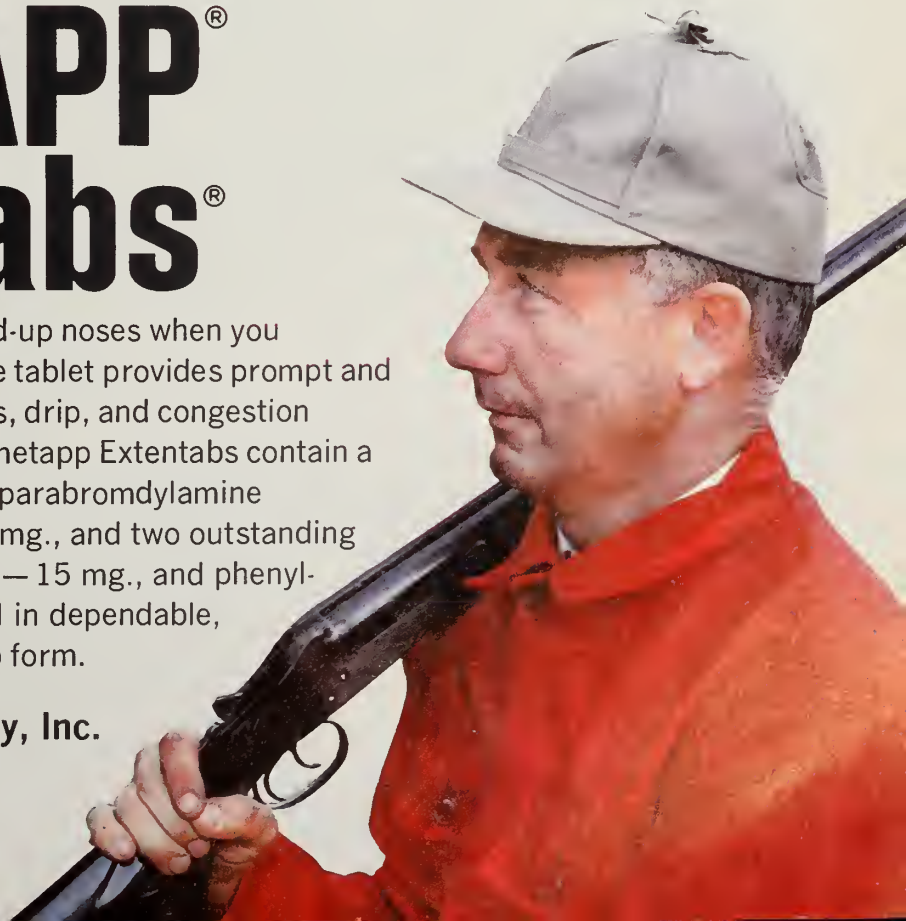
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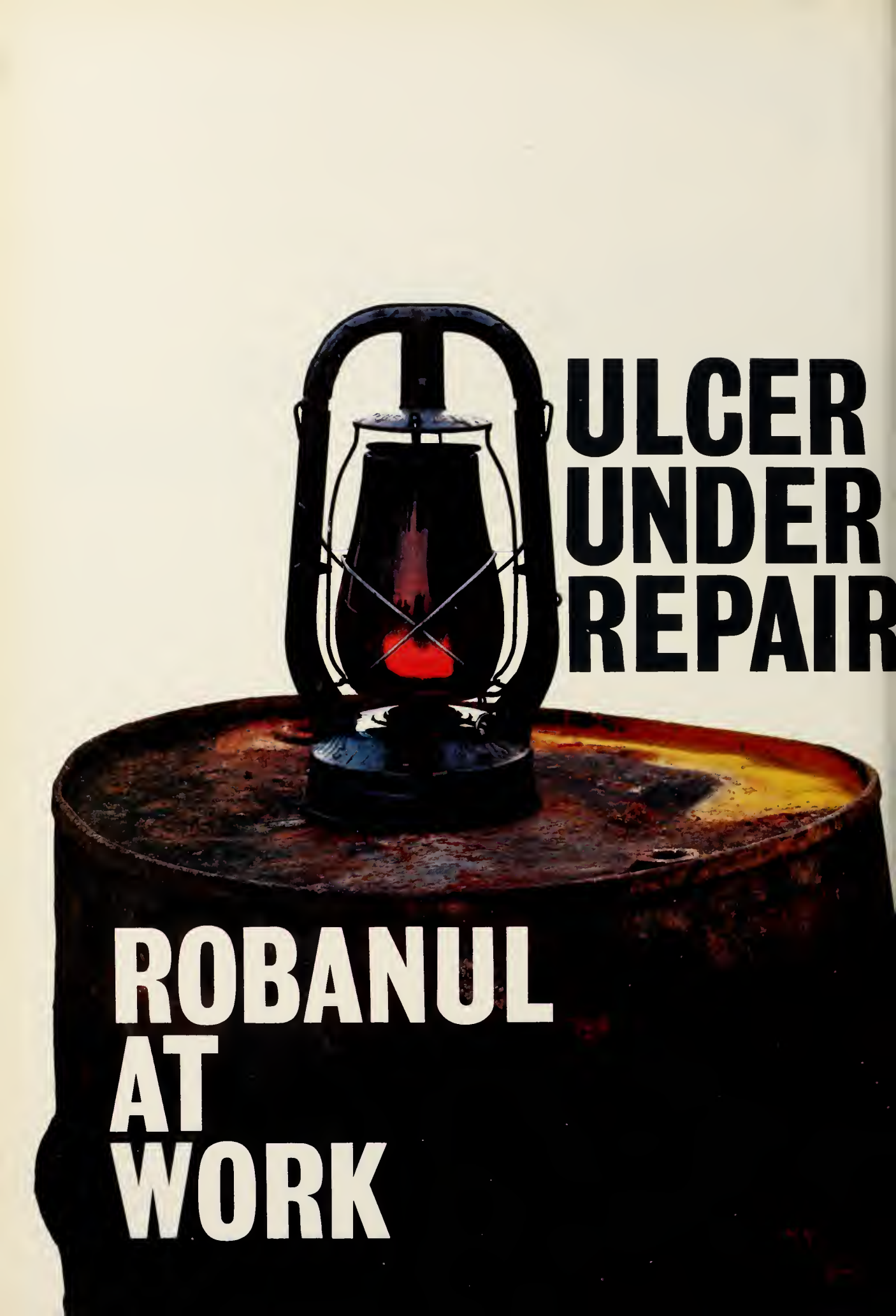
in sinusitis, colds, U.R.I.,
10-12 hours
clear breathing on 1 tablet

# DIMETAPP® Extentabs®

It's always Open Season on stopped-up noses when you prescribe Dimetapp Extentabs. One tablet provides prompt and prolonged relief from the stuffiness, drip, and congestion of upper respiratory infections. Dimetapp Extentabs contain a proven antihistamine, Dimetane® [parabromdylamine (brompheniramine) maleate]—12 mg., and two outstanding decongestants, phenylephrine HCl—15 mg., and phenyl-propanolamine HCl—15 mg.... all in dependable, long-acting (10-12 hours) Extentab form.

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ULCER
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# New Robanul™ signals a major improvement in duodenal ulcer therapy

From Robins research comes Robanul (generically, Glycopyrrolate), first of the "rigid-ring" anticholinergics, representing what may well be the most important advance in anticholinergic chemistry in a decade.

Clinically, both Robanul and Robanul-PH (with phenobarbital) have demonstrated a remarkable ability to provide within 90 minutes—and maintain for 6 to 10 hours—those nearly ideal pharmacologic healing conditions that mean prompt relief of ulcer pain and a successful recovery of your ulcer patient.

There are always important questions about any new therapeutic agent. Below are answers to some of the common ones asked about Robanul:

## ROBANUL™

Glycopyrrolate (Robins), 1.0 mg. per tablet (U.S. Pat. No. 2,956,062)

## ROBANUL™-PH

Robanul with phenobarbital, 16.2 mg. per tablet

**First of all, what does "rigid-ring" mean?**

Briefly, this: it describes the use of a fixed pyrrolidine pentagon, or rigid ring, which guarantees a constant 2-carbon distance between reactive parts of the molecule. In line with the "receptor site" concept of the mechanism of action of anticholinergics, this almost inflexible molecule is theoretically more likely to "fit" only certain receptor sites.

**Theories are all right, but is Robanul really more selective?**

Yes! Evidence of its selectivity can be seen by the surprising lack of typical secondary anticholinergic effects (dry mouth, blurred vision, etc.) that occur at the effective dosage level of 1 to 4 mg. a day. Out of 499 duodenal and gastric ulcer patients treated at this level in investigative studies, only 4.4% had complaints of moderate to severe effects.

**How is it for reducing gastric acid?**

One investigator[1a] found that a 2 mg. dose of Robanul lowered acid secretion 73% in one hour (compared to a basal-hour period) and 84% in two. A 4 mg. dose dropped secretion over 94% in one hour and 97% in two!

**What about acidity, or concentration of acid?**

In one study, glycopyrrolate produced significant suppression of pH to 4.5 or higher in 5 of 5 duodenal ulcer patients given a 4 mg. dose, 7 of 8 patients given 2 mg., and 4 of 5 patients given 1 mg.[1b]

**Will Robanul depress gastric hypermotility?**

In another study[2] with six subjects Robanul decreased gastric motility in every patient. Within 40 minutes after the administration of 2 mg. of Robanul, the frequency of gastric antral contractions decreased from 1 every 24 seconds to only 1 every 2½ minutes. Young and Sun[1c] found a similar effect. Moreover, their results in 7 patients indicated that Robanul, in a dose of 2 mg., did not produce delay in gastric emptying or intestinal transit.

**What's the best dosage schedule for Robanul?**

It should be adjusted for each patient, and this is where Robanul offers another big advantage. Its "titratability" is unmatched among anticholinergic agents. Robanul's potency makes possible a recommended starting dose of only one milligram t.i.d. Yet its selectivity usually permits much leeway for dosage adjustment upward as necessary, to achieve the most effective dose level for each patient while maintaining a low incidence of undesirable effects on other organ systems.

**Is there anything else Robanul does for peptic ulcer?**

Much more! For instance, 2 mg. cuts pepsin production about 50% in two hours; 4 mg., about 65%.[1a]...There is evidence that Robanul combats hormonal aspects of gastric secretions as well as vagal in many patients... ...Its activity lasts long enough to reduce acid secretion all night long.[3]...Many ulcer patients have remarked about its fast relief of pain....

**One last question:** Why not prescribe Robanul for your next duodenal ulcer patient and see for yourself just exactly how effective it is?

References: 1. From the New York Academy of Sciences, Conference on Peptic Ulcer, Oct., 1961. (a) H. C. Moeller. (b) D. C. H. Sun. (c) R. Young and D. C. H. Sun. 2. W. C. Breidenbach: Investigative clinical report, March, 1961. 3. I. A. Feder: Investigative clinical report, May, 1961.

Additional information upon request.

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PHARMACEUTICALS · RESEARCH

(Continued from Page 210)

sibility of legal action against the physician increases if it can be shown that a transfusion accident occurred when there was a questionable need for the procedure in the first place.

"To avoid legal liability in deaths or injuries result from transfusions, the physician and the hospital must exercise reasonable care to avoid the use of blood which contains virus contamination. The physician must also make sure that the blood transfusion was necessary, for if it can be proven otherwise, he can be liable for damages caused by contaminated blood."

## CONGRESSMAN OFFERS GOOD SUGGESTION

"Nothing is as powerful in directing the action of a Congressman as pressure from his own constituents, whose votes keep him in office."

Thus writes Congressman Bruce Alger, Fifth Texas District, in his "Washington Report," so it must be the gospel.

Give this advice a whirl. It may pay big dividends.

## NEW FORM WILL HELP IN CONSULTATIONS

The Ohio Academy of General Practice is to be commended for having devised a "Consultation or Referral Request" form, copies of which may be purchased in quantities from the Academy, 1500 West Third Avenue, Columbus. In a concise way, with check-off boxes, the exact disposition of the patient is clearly outlined. There is space for the consultant's written report and recommendations.

Use of this form by referring physicians and consultants should go a long way toward eliminating many misunderstandings; also it would be in the interest of better patient care. It is essential that the referring physician be specific and that he supply the consultant with all pertinent data. By the same token, the consultant should do what the referring physician asks him to do and he should be sure to complete and send a full report. Use of this newly drafted blank will help both of them to do a better job.

## CORPORATE IMAGE IS SUM TOTAL OF MANY

One hears frequently that Joe Doaks likes his doctor but hasn't much use for his organization — local, state or national. Is this truth or fancy? An editorial in the *New York State Journal of Medicine* leads one to believe that before the corporate image can improve its status, the individual physician will have to try harder to improve his own reputation among his patients. Here's the way the N. Y. Magazine sized up the matter:

"One of the preoccupations of our times is to view our corporate image. None escape — our nation, our cities, and our businesses and professions are all under scrutiny in this regard. There are serious lessons to be learned from this modern type of narcissism.

"A recent private poll by the editor of one of our large daily papers in this State asked the question, 'What do you think of doctors?' The editor asked this question personally of random subscribers and friends.

"Surprisingly enough, criticism was directed not particularly to the actions or inactions of organized medicine but to the individual doctor's conduct of his practice. Almost universal were the complaints of lack of a warm, understanding contact with the physician, wholesale referral to specialists, particularly for simple, uncomplicated conditions, and high costs, including hospitalization and drug costs which are largely out of the control of the doctor.

"Numerous were the complaints of inability to get the doctor 'when I want him.' This was not a night call problem but one which happened during the business hours of the day. 'The doctor is not punctual' was often heard. Sad to relate, there was some criticism of an occasional one of our own who loaded on an extra fee to insurance service benefits which had been firmly agreed on.

"There was much praise too for skill and competence. The people like and admire *what* we do, but they are less than enthusiastic about *how* we do it.

"The corporate image is the sum total of the individual images. We will *look* better when we *are* better.

"Tightening up in extravagances in hospitalization and drug prescribing, closer attention to our patients and a human, holistic approach to their problems, and prudence in referral would please our patients and might not do us a bit of harm as we face into the winds of change."

## MEDIATION COMMITTEE MUST HAVE COURAGE

Is it the responsibility of a Mediation Committee (Grievance Committee) to determine if and when fees are excessive? Is it the responsibility of members of a Mediation Committee to testify in event the dispute regarding fees is taken to court.

"Yes" is the answer given by the Board of Directors of the Cleveland Academy of Medicine to both questions, asked by the Academy's Mediation Committee. In making the decision the Board of Directors noted that a few exceptional cases of over-charging tend to stigmatize the entire profession and that the vast majority of physicians should be protected from such ill-founded charges, meaning that mediation committees should make a decision and should be ready to back it up in court if necessary.

In our opinion this is a statesmanlike decision on the part of the Cleveland Academy board. Similar action by all county medical societies would be a long step in the right direction in breaking up abuses which, although few in number, reflect adversely on the reputations of all physicians.



## *in alcoholism: vitamins are therapy*

A full "comeback" for the alcoholic is partly dependent on nutritional balance...aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished...from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins. Supplied in decorative "reminder" jars of 30 and 100.

| Each capsule contains: | |
|---|---|
| Vitamin $B_1$ (Thiamine Mononitrate) | 10 mg. |
| Vitamin $B_2$ (Riboflavin) | 10 mg. |
| Niacinamide | 100 mg. |
| Vitamin C (Ascorbic Acid) | 300 mg. |
| Vitamin $B_6$ (Pyridoxine HCl) | 2 mg. |
| Vitamin $B_{12}$ Crystalline | 4 mcgm. |
| Calcium Pantothenate | 20 mg. |

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

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Obituaries

# Ad Astra

Sanford Bundy Barrett, M. D., Cuyahoga Falls; Starling Medical College, Columbus, 1901; aged 82; died January 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Barrett began his practice in Randolph and moved to the Akron area in 1914 where he maintained his practice until his retirement in 1957. Among affiliations, he was a member of the Masonic Lodge. His daughter survives.

Maynard Ardeen Buck, M. D., Niles; Ohio State University College of Medicine, 1923; aged 65; died December 7 shortly after returning from a trip abroad; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Buck had been a practicing physician in Niles for 35 years. A veteran of World War I, he was a member of the Presbyterian Church and several Masonic bodies. His son survives.

Elizabeth Maud Bull, M. D., Marion; Starling Medical College, Columbus, 1907; aged 89; died December 24; former member of the Ohio State Medical Association and the American Medical Association. Dr. Bull was a resident of Marion for most of her life and practiced there for more than a half century. A member of the Seventh-Day Adventist Church, she is survived by three nephews, one of whom is Dr. John W. Bull, also of Marion.

James Sankey Deering, M. D., Cleveland; Western Reserve University School of Medicine, 1922; aged 65; died December 10, member of the Ohio State Medical Association and the American Medical Association. Dr. Deering practiced for some 40 years in Cleveland. He was a member of the Catholic Church and the Knights of Columbus and was active in other Catholic organization work. Survivors include a daughter and two brothers.

Francis Clyde Duckwall, M. D., Van Wert; Miami Medical College, Cincinnati, 1903; aged 85; died November 27; member of the Ohio State Medical Association and the American Medical Association. A native of Darke County, Dr. Duckwall began his practice in Scott, north of Van Wert and moved to Van Wert in 1924. He was a veteran of World War I, a member of the Presbyterian Church and the Masonic Lodge. Surviving are a daughter and a son, Dr. Vernon Duckwall of Elkins, W. Va.

Ernest Rudolphus Gamble, M. D., Cleveland Heights; Eclectic Medical College, Cincinnati, 1905; aged 83; died December 25; former member of the Ohio State Medical Association. Dr. Gamble practiced in the Cleveland area from about 1921 to 1949 when he retired. He was a 50-Year Mason and a member of the Methodist Church of the Savior. Survivors include his widow and two daughters.

William Leroy Hann, M. D., West Unity; Hahnemann Medical College and Hospital of Philadelphia, 1934; aged 57; died November 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Hann opened his practice in West Unity after completing an internship at the Miami Valley Hospital in Dayton. During World War II he served with the Navy Medical Corps and attained the rank of lieutenant colonel. Survivors include his widow, a son and a brother.

Robert Beebe Hauver, M. D., Cleveland; Western Reserve University School of Medicine, 1922; aged 65; died December 12; member of the Ohio State Medical Association, the American Medical Association, American Academy of Pediatrics; diplomate of

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the American Board of Pediatrics. A practicing physician in Cleveland for many years, Dr. Hauver was professor of pediatrics at Western Reserve University. He was a past-president of the Northeast Ohio Pediatrics Society and among activities in the Academy of Medicine was current chairman of the Poison Prevention Committee. Survivors include his widow, a daughter and a son, Capt. Robert C. Hauver, U. S. Air Force Medical Corps, stationed in England.

**William Stuart Henderson,** M. D., Akron; University of Toronto Faculty of Medicine, 1923; aged 61; died December 9; member of the Ohio State Medical Association, the American Medical Association and the American College of Gastroenterology. Dr. Henderson practiced internal medicine from about 1926 in Akron where he was one of the founders of the Akron Clinic. Affiliations included membership in the Kiwanis Club, the Presbyterian Church and several Masonic bodies. Surviving are his widow, a daughter, his mother and a sister.

**Raymond Charles King,** M. D., Toledo; St. Louis University School of Medicine, 1918; aged 66; died January 3; member of the Ohio State Medical Association, the American Medical Association, American Association of Obstetricians and Gynecologists, American College of Obstetricians and Gynecologists, International College of Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. Dr. King was a lifelong resident of Toledo and served all of his professional career there with the exception of time in graduate training. He was a member of the Elks Lodge, the Catholic Church and the Knights of Columbus. Survivors include his widow and a daughter.

**Karl V. Kitzmiller,** M. D., Cincinnati; University of Cincinnati College of Medicine, 1923; aged 63; died January 4; member of the Ohio State Medical Association, American Medical Association, American College of Clinical Pathology, Industrial Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. A physician for a number of years in Cincinnati, Dr. Kitzmiller was associate professor of industrial medicine at the University of Cincinnati and associate medical director of the Ethyl Corporation. Surviving are his widow and a son, Dr. Karl W. Kitzmiller, also of Cincinnati.

**Chester Henry Kocinski,** M. D., Lakewood; Toledo Medical College, 1913; aged 72; died December 10. Dr. Kocinski practiced for about 25 years in the Lakewood and Cleveland area before he retired in the early 1950's for health reasons. He was a veteran of World War I. Surviving are his widow, two daughters and two sisters.

**Maurice Bernard Menke,** M. D., Dayton; Ohio State University College of Medicine, 1928; aged 62; died December 5; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Ophthalmology. A native of Greenville, Dr. Menke practiced for many years in Dayton where he specialized in ophthalmology and otolaryngology. He is survived by his widow, two daughters and a sister.

**Charles Graham Rogers,** M. D., Dayton; Central College of Physicians and Surgeons, Indianapolis, 1894; aged 94; died December 18; former member of the Ohio State Medical Association. Dr. Rogers practiced for some 60 years in Dayton. He was a member of the AME Church of Dayton. Survivors include his widow and a son.

**James Bernard Rucker,** M. D., Toledo; University of Pennsylvania School of Medicine, 1904; aged 82; died December 20; member of the Ohio State Medical Association and the American Medical Association. Dr. Rucker moved to Toledo in 1923 after doing public health work in Pennsylvania. He served in the Army Medical Corps during the Mexican Border Incident and later became a medical officer in the Navy reserve. He was a member of the Episcopal Church, several Masonic bodies, Sons of the American Revolution. Survivors include four daughters, a sister and a brother.




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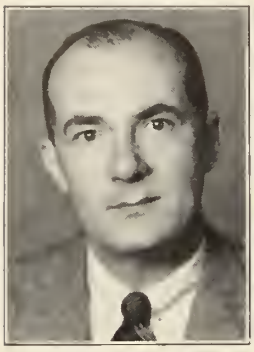
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## Columbus Physician Named to AMA Committee on Sports

Dr. Thomas E. Shaffer, Columbus, has been named a member of the American Medical Association's Committee on the Medical Aspects of Sports. Dr. Shaffer is a member, and former chairman, of the Ohio State Medical Association's Committee on School Health, and has been active in the High School Athletic Injury Prevention program sponsored in Ohio jointly by the OSMA and the Ohio High School Athletic Association.



Dr. Shaffer

A Columbus practitioner in pediatrics for many years, Dr. Shaffer is currently medical director for the Juvenile Diagnostic Center. Other appointments include that as professor of pediatrics and preventive medicine at Ohio State University College of Medicine.

Chief purposes of the Committee on the Medical Aspects of Sports are: (1) To advise athletic personnel on the various phases of the health supervision of sports, and (2) to disseminate information to interested physicians on the application of medical skills in the athletic situation.

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### Symposium on Role of Food In World Peace

An International Symposium on the Role of Food in World Peace will be held April 30 and May 1 and 2 by Ohio State University as one of the major activities in connection with the centennial of the establishment of the Land Grant College and University System in the United States. Some of the topics which will be covered are: "The Nutritional State of the World"; Are Food and Peace Sequential — Is There An Historical Answer?"; "Food for an Exploding World Population"; and "Economic Implications of Food for World Peace." National and international speakers will participate. Physicians who may be interested in attending should write Mrs. Eva D. Wilson, Department of Home Economics, 1787 Neil Avenue, Ohio State University, Columbus 10, for more details.

---

Enrollment in the nationwide Blue Shield Plans passed the 48,400,000 mark as of September 30, 1961. Total membership in the 75 medical-surgical Blue Shield Plans amounted to 48,415,337, as a result of a net gain of 1,330,349 new members during the first nine months of 1961. Blue Shield now covers one out of every four Americans, and almost 15 per cent of the total Canadian population.

## Advice for Physicians Liable For Military Service

National Advisory Committee to Selective Service has sent the following suggestions to the deans of schools in the health professions, to hospital administrators, chief of hospital educational programs, heads of departments in health institutions and those in relevant fields:

That those faculty members who are members of ready reserve units, as they become increasingly important to the school, be asked to submit their resignations and request transfer to the standby reserve.

That those in residency training programs who are in ready reserve units, ask for similar transfers and those liable SSS classifications, appeal a classification of "I-A Examined and Acceptable" within ten days of receiving such classification to the SSS Appeal Board in the area in which they are serving their residency (whether it be in the same state as their local board is located or not). This appeal should be supported by statements from the hospital authorities as to the essentiality of the resident to the patients of the individual completing that full year of residency (be it first, second or third).

That those students and interns who are in *ready* reserve units in such capacities as pilots, etc., ask for transfer to the Early Commissioning Program.

The National Advisory Committee is making these suggestions for the purpose of helping to evaluate the needs of the military and civilian population for present and future supplies of highly trained health personnel.

The NAC is anxious to help the military determine just how ready the ready reserve is and if not ready enough, to help establish a true ready reserve.

The NAC at the same time feels that it is necessary for civilian institutions to determine what a call-up of ready reserve units would mean to them, and to make plans now to adjust their planning at present or be prepared to adjust on sudden notice to the loss of those individuals who are members of ready reserve units.

---

### Nutri-Bio Salesmen Warned

The Food and Drug Administration cautioned an estimated 75,000 distributors of products of the Nutri-Bio Corporation, Beverly Hills, Calif., that the legality of the basic sales promotion materials used by the parent firm has been challenged by a November 24 seizure action against Nutri-Bio in the District of Columbia.

FDA warned the Nutri-Bio distributors that continued use of Nutri-Bio sales material alleged by the government to be false and misleading may subject them to federal prosecution and their merchandise subject to seizure. The material includes the Nutri-Bio General Manual, Sales Manual, and other literature furnished by the corporation.

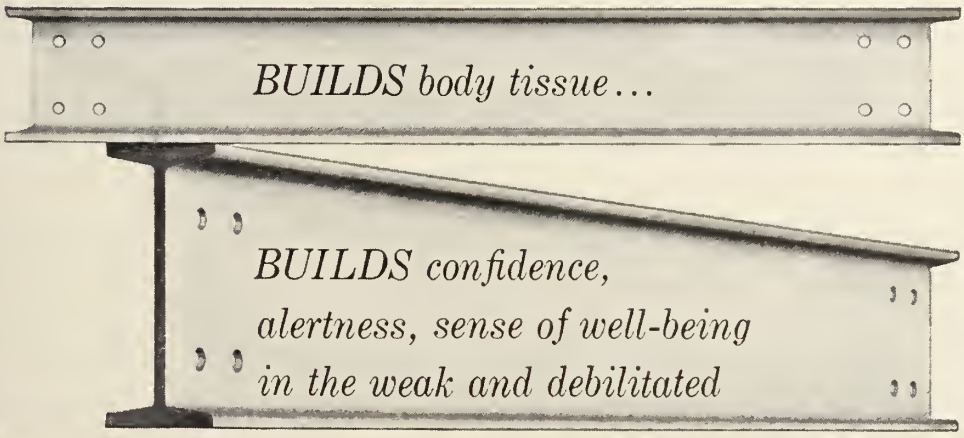
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*animal data

Complete bibliography and literature available on request. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

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# Activities of County Societies...

## First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

### CLERMONT

Dr. Phillips F. Greene, New Richmond, is the new president of the Clermont County Medical Association, it was announced.

Dr. Lloyd E. Owens, Milford, is vice-president, and Dr. R. Kirby Lancaster, Summerside, secretary-treasurer.

Dr. Charles M. Simmons, Bethel, was appointed delegate to the Ohio State Medical Association, with Dr. D. K. Ebersold, Milford, alternate. Dr. Harry M. Breuer, New Richmond, was named censor.—*Loveland Herald.*

### HAMILTON

The Academy of Medicine of Cincinnati in cooperation with the Cincinnati Society of Internal Medicine sponsored a program on December 12 on the subject, "Diagnosis of Hemorrhagic Diseases." Guest speaker was Dr. Oscar D. Ratnoff, professor of medicine at Western Reserve University, Cleveland.

A number of specialty societies also held meetings during the month.

## Second District

(COUNCILOR: RAY M. TURNER, M. D., SPRINGFIELD)

### GREENE

Dr. Alvin Salisbury of Fairborn was elected president of the Greene County Medical Society at its annual meeting Tuesday evening (Dec. 14) at Greene Memorial Hospital. A dinner preceded the business meeting.

Other new officers for 1962 are Dr. Eugene Schmitt, Xenia, vice-president; Dr. John Wolff, Xenia, secretary-treasurer; Dr. B. F. Lee of Xenia, D. Paul Vernier of Fairborn and Dr. R. D. Hendrickson of Xenia, board of censors, and Dr. Roger C. Henderson of Xenia, delegate, with Dr. C. G. McPherson of Xenia as alternate. Mrs. C. K. Elliott retained her post as executive secretary for the society.—*Xenia Daily Gazette.*

### MIAMI

Dr. Dale Hudson, of Piqua, was elected president of the Miami County Medical Society Tuesday night (Dec. 5) at the Troy Country Club.

Dr. Paul Foy, of Troy, was named vice-president and Dr. Jack P. Steinhilber, of Piqua, was named secretary-treasurer.

## Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

### ALLEN

Dr. Roy E. Bushong, former superintendent of Lima State Hospital, was honored at a recent meeting of the Academy of Medicine of Lima and Allen County, with the 50-Year Award of the Ohio State Medical Association. Dr. Floyd Elliott, Ada, Councilor of the Third District, presented the button and certificate.

A joint meeting of physicians and pharmacists of the area was held recently at the Lost Creek Country Club. Don R. Hall, manager of trade relations for the Upjohn Company, spoke deploring governmental regulations which would discriminate against trade name drugs. Another speaker was Dr. A. B. Burns,


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Van Wert, who spoke in behalf of the Chamber of Commerce of which Dr. Burns is local president.

### AUGLAIZE

Dr. Robert S. Oyer was named president of the Auglaize County Medical Society at a meeting Thursday (Dec. 14) in St. Marys.

He replaces Dr. R. M. Rabe. Other officers are Dr. J. R. Romaker, vice-president, Dr. R. S. Sobocinski, secretary-treasurer, Dr. E. Y. Kuffner, delegate, and Dr. Clyde W. Berry, alternate.—*Sidney Daily News.*

### CRAWFORD

Dr. K. H. Barth, Dr. and Mrs. Daniel Kenny, and Dr. and Mrs. L. James Barth of New Washington attended the annual Crawford County Medical Society Dinner Meeting which was held in December at the Greenlawn Restaurant on Route 30. Dr. L. James Barth was elected president of the group, Dr. K. H. Barth was elected vice-president, while Dr. Kenny was elected secretary-treasurer for the coming year.

## Fourth District

(COUNCILOR: EDWIN R. MURBACH, M. D., ARCHBOLD)

### DEFIANCE

Defiance County Medical Society elected officers at its monthly meeting (Dec. 2) in the hospital conference room.

The new officers are: President, Dr. Francis M. Lenhart; vice-president, Dr. G. A. Huber; and secretary-treasurer, Dr. William F. Busteed. The latter was reelected for a second term.

Dr. Lenhart succeeds Dr. John U. Fauster, Jr.—*Defiance Crescent News.*

### LUCAS

The Sixtieth Annual Meeting of the Academy of Medicine of Toledo and Lucas County was held on January 11 at the Commodore Perry Hotel where a social hour, dinner and program was held.

Guest speaker was Professor Raymond W. Mack, chairman of the Department of Sociology, Northwestern University, Evanston, Ill. His subject, "The Challenge of Change — The Independent Professions and the Welfare State."

### PUTNAM

Dr. Walter S. Donahue, Leipsic physician, was named president of the Putnam County Medical Society at a meeting of the group held last Tuesday (Dec. 12) in Kalida.

Other officers are:

Dr. Oliver N. Lugibihl, Pandora, vice-president, and Dr. John R. Brown, Ottawa, secretary-treasurer. —*Leipsic Free Press.*

### WOOD

Dr. J. R. Janney has been elected president of the Wood County Medical Society. Other officers are Dr. L. P. Baldoni, vice-president, and Dr. William S. Rothe, secretary-treasurer.

A dinner meeting for members and wives was held Dec. 14 in the Old Plantation Inn at Maumee. *Daily Centinel-Tribune.*

## Fifth District

(COUNCILOR: HENRY A. CRAWFORD, M. D., CLEVELAND)

### ASHTABULA

The Ashtabula County Medical Society elected officers for 1962 at its December meeting.

Speaker for the evening was Dr. Leonard Lorshin, who heads the Department of Internal Medicine at Cleveland Clinic. His topic was "Headaches."

The new officers are William J. McCarthy, M. D., president; Robert Zimmerman, M. D., vice-president, and Reginald Shelby, M. D., secretary-treasurer.—*Jefferson Gazette.*

### CUYAHOGA

The theme "Should Physicians Incorporate?" was discussed by a panel at the December 11 dinner meeting of the Academy of Medicine of Cleveland and Cuyahoga County. Included on the panel were the following:

Dr. George W. Petznick, Cleveland, president of the Ohio State Medical Association, "Ethical Considerations of Professional Incorporation."

Gerald F. Weber, President of Gerald F. Weber

*(Continued on Page 226)*

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## effective anxiety control with a wide margin of safety




**in the "frantic forties"**—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

In each of these areas, VISTARIL is often effective alone or as an adjunct to other therapy. For example, in his series of 67 patients, King[1] found that 62 showed remission of anxiety, tension, nervousness and insomnia, as well as alleviation of symptoms associated with various functional and psychophysiological disturbances. He concludes that VISTARIL is well suited for use in the practice of internal medicine.

In the emergent situation, VISTARIL, administered parenterally, is a valuable aid to the physician in managing patients who escape psychic conflict via alcohol. According to Weiner and Bockman,[2] who obtained beneficial results in 81% of 175 patients studied, hydroxyzine (VISTARIL) may well be considered a tranquilizer of choice in the management of the acutely agitated alcoholic.

1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

VISTARIL® CAPSULES AND ORAL SUSPENSION
HYDROXYZINE PAMOATE

VISTARIL® PARENTERAL SOLUTION
HYDROXYZINE HYDROCHLORIDE

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IN BRIEF VISTARIL®

VISTARIL, hydroxyzine pamoate (oral) and hydroxyzine hydrochloride (parenteral solution), is a calming agent unrelated chemically to phenothiazine, reserpine, and meprobamate.

VISTARIL acts rapidly in the symptomatic treatment of a variety of neuroses and other emotional disturbances manifested by anxiety, apprehension, or fear—whether occurring alone or complicating a physical illness. The versatility of VISTARIL in clinical indications is matched by wide patient range and a complete complement of dosage forms. The calmative effect of VISTARIL does not usually impair discrimination. No toxicity has been reported with the use of VISTARIL at the recommended dosage, and it has a remarkable record of freedom from adverse reactions.

**INDICATIONS:** VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

**ADMINISTRATION AND DOSAGE:** Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

**SIDE EFFECTS:** Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

**PRECAUTIONS:** Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

**SUPPLIED:** VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

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*(Continued from Page 223)*

& Associates, of Los Angeles, Calif., "The Doctor and His Dollar."

George Meisel, attorney partner in the firm of Squire, Sanders & Dempsey, "Legal Considerations of Professional Incorporation."

Charles D. Meckes, vice-president of the Central National Bank of Cleveland, "Setting Up a Retirement Program."

## Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

### COLUMBIANA

Doctors affiliated with the Columbiana County Medical Society and their wives held their annual Christmas dinner last Sunday night (Dec. 10) at Valley View Country Club with 40 couples in attendance.

Entertainment featured a description by Mr. and Mrs. Maurice Michaud of Columbiana of their trip to Switzerland, illustrated with slides.

In a brief business meeting, Dr. Fred Banfield of East Liverpool was elected president for 1962, succeeding Dr. Leonard Pritchard of Columbiana.

Under the election system used by the society, Dr. V. C. Hart of Salem was named president-elect for 1963.

Dr. Janis Lauva of Wellsville was named secretary-treasurer for 1962.—*Columbiana Ledger.*

### MAHONING

Three veteran members of the Mahoning County Medical Society were honored for a half century of service in the medical profession at the November 21 meeting of the Society.

Receiving 50-Year Awards at the meeting were Dr. F. W. McNamara and Dr. Michael S. Zervos. Dr. Robert E. Tschantz, Canton, Sixth District Councilor made the presentations.

The third recipient of the 50-Year Award was Dr. Charles Scofield who was unable to attend.

Dr. C. W. Stertzbach advanced to the presidency of Mahoning County Medical Society at the annual meeting Tuesday night (Dec. 20) at the Mural Building.

Dr. Stertzbach took office Jan. 1, succeeding Dr. A. K. Phillips, who presided at Tuesday night's dinner meeting. Dr. Asher Randell was chosen president-elect.

Dr. C. E. Pichette was reelected secretary while Dr. H. P. McGregory continues as treasurer.—*Youngstown Vindicator.*

* * *

The Mahoning County Medical Society became the first medical society in the country to undertake a large scale mass immunization program with newly licensed Sabin oral vaccine.

Type I vaccine was given in a two-day program, organized by Dr. Kurt Wegner, chairman of the polio committee of the Society. A total of 134,671 persons came to the 18 polio stations set up in Youngstown



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The outstanding effectiveness and safety with which Miltown calms tension and nervousness has been clinically authenticated by thousands of physicians during the past six years. This, undoubtedly, is one reason why meprobamate is still the most widely prescribed tranquilizer in the world.

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meprobamate (Wallace)

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***Supplied:*** 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS®—400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

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Clinically proven
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1 Acts dependably — without causing ataxia or altering sexual function

2 Does not produce Parkinson-like symptoms, liver damage or agranulocytosis

3 Does not muddle the mind or affect normal behavior

and Mahoning County. The project was termed highly successful by Mahoning physicians.

The program was conducted on Thursday, November 30 and Saturday, December 1. All but two stations were situated in school buildings. Ten were within the city limits and eight were out in the county.

Type II vaccine was scheduled to be given in a similar two-day program to take place at the end of January. If Type III becomes licensed in time, the third immunization will be given in the Spring. If it is not licensed, the third program will be delayed until the vaccine is available.

The immunization was financed on the basis of a fifty-cent fee for each person. No one was turned away if he could not afford the fifty cents, and the medical society will make up the difference if the program goes into the red. If there is an excess, the money will be turned over to a recognized charity at the end of the program.

At each station there was one physician, two pharmacists, and two nurses, along with ten lay persons. After the first day, certain stations had to double their staffs for the crowds that came out on Saturday. Many of the stations were held open past the announced closing time in order to accommodate the crowds. A member of the medical society woman's auxiliary headed the lay staff at each station and almost all of the auxiliary members served on a staff.

The gratifying turn-out, which found long lines at almost all of the stations, was attributed to an all-out information and publicity campaign carried out through the *Youngstown Vindicator,* four television stations and six radio stations. Flyers were sent to the schools for each child to take home. Posters were displayed in the grocery chains, drug stores and public places. The television stations gave saturation coverage on children's programs for two weeks before the date of the immunization.

Although the campaign was planned specifically for Mahoning County, no one from surrounding counties was turned away. The age limits stressed were from birth to 50 years old, but no one over 50 was denied the immunization.

The population of Youngstown is 168,000, and the estimated under 50 population of Mahoning County is 230,000.

### STARK

New officers were installed and two physicians were honored Thursday night (Dec. 14) for 50 years of service at a meeting of the Stark County Medical Society at Mergus Restaurant (Canton).

The new president of the society is Dr. Graydon Underwood of Navarre. He succeeds Dr. Maurice Lieber of Canton.

Highlight of the meeting was the presentation of awards to two Stark County men who are marking 50 years in the medical profession. They are Dr. Earl Musselman of Alliance and Dr. A. R. Olmstead.

Dr. Musselman still maintains a private practice

*(Continued on Page 231)*

**PREDNISONE**
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**COOK COUNTY GRADUATE SCHOOL OF MEDICINE**

CONTINUING EDUCATION COURSES
STARTING DATES — SPRING, 1962

Surgical Technic, Two Weeks, April 2, June 4
Surgery of Colon & Rectum, One Week, March 5, June 4
Advances in Surgery, One Week, March 19
Plastic Surgery of Head and Neck, One Week, April 9
Basic Principles in General Surgery, Two Weeks, April 23
General Surgery, One Week, May 7; Two Weeks, April 2
Gynecology, Office & Operative, Two Weeks, April 9
Vaginal Approach to Pelvic Surgery, One Week, Mar. 26
Obstetrics, General & Surgical, Two Weeks, March 12
Pain Relief in Childbirth, 3 Days, March 7
Proctoscopy & Sigmoidoscopy, One Week, March 26
Treatment of Varicose Veins, One Week, March 26
Basic Internal Medicine, Two Weeks, March 26
General Practice Review, One Week, May 21
Basic Electrocardiography, One Week, March 19
Gallbladder Surgery, 3 Days, March 12
Surgery of Hernia, 3 Days, March 15
Urology, Two Weeks, April 2
Surgery of the Hand, One Week, April 16.

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ATTENDING STAFF OF COOK COUNTY HOSPITAL
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# you had to make your own children's multivitamins

...hances are you'd try to make them very much like our new Vi-Daylin® Chewable with Entrapped Flavor. ...apped Flavor means a better tasting chewable children's multivitamin; one with no vitamin aftertaste. Here's ...: 1. We coat all the vitamins in a digestible film that does not dissolve until it reaches the gastrointestinal tract. ...s means that unpleasant strong vitamin tastes are not released in the mouth, but in the g-i tract where they ... most quickly absorbed. 2. We make certain that every Vi-Daylin Chewable tablet tastes citrus sweet ... good to every patient, everytime; we coat the flavoring oils in each tablet in a water soluble film. This ... dissolves immediately in the mouth, releasing the full bouquet of our citrus-candy flavoring agents. Now ... know why little patients always taste the flavor, never the vitamins, when you prescribe ... Vi-Daylin Chewable. And the formula's all you'd expect, with reasonable amounts of A & D. ...te test them yourself and you'll prescribe **VI-DAYLIN CHEWABLE** regularly and soon.

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# Profile of a multivitamin




## New Vi-Daylin Chewable —with entrapped flavor

**New Formula**

In recognition of recent medical thinking, we've reduced the vitamin D in our formula from 20 mcg. (800 units) to 10 mcg. (400 units). At the same time, we've increased the vitamin C content from 40 mg. to 50 mg. per tablet and per 5-cc. lemon-candy teaspoonful.

**All Other Elements Remain at Their Previous Level.**

| | |
|---|---|
| Vitamin A (3000 units) | 0.9 mg. |
| Thiamine Mononitrate | 1.5 mg. |
| Riboflavin | 1.2 mg. |
| Cobalamin ($B_{12}$) | 3 mcg. |
| Nicotinamide | 10 mg. |
| Pyridoxine Hydrochloride | 1 mg. |

**New Low Price**

In quantities of 100 tablets our new Chewable costs less than 4¢ a tablet and the normal dosage is one tablet daily. No financial hardship for your patients when you prescribe or recommend Vi-Daylin.

**New Shape, New Color, New Bottle**

New Vi-Daylin Chewable tablets are football shaped. This shape got a high degree of acceptance in our taste-tests and seems to have an intrinsic interest for children. The orange color ties in with the mild, sweet citrus flavor. And the wide-mouthed new bottle looks handsome on the table.

**Taste-Test New Vi-Daylin Chewable Yourself**

Won't you taste-test new Vi-Daylin Chewable multivitamins yourself? We're certain you'll be pleasantly surprised at their sweet good taste. They're the candy-flavored multivitamins with *entrapped flavor* . . . little folks taste the candy flavor, never the vitamins.

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VI-DAYLIN—Vitamins A, D, $B_1$, $B_2$, $B_6$, $B_{12}$, C, and Nicotinamide, Abbott

(Continued from Page 228)

at his office in the City Savings Bank Building in Alliance.

Dr. Olmstead is retired and resides in Florida.

The awards were presented by Dr. R. E. Tschantz, Sixth District Councilor for the Ohio State Medical Association.

Other new officers installed Thursday include Dr. J. L. Yahraus, president-elect for 1963; Dr. J. H. Bahrenburg, Jr., secretary-treasurer, and Dr. Keith C. Noble of Alliance, censor.—*Canton Repository.*

### SUMMIT

Dr. F. M. McDonald assumed office as president of the Summit County Medical Society on January 1. He takes office with the following other officers who were elected at a recent meeting: President-Elect, Donald E. Leonard; Secretary, Charles E. Casto; Councilor, H. Willard Allison; Delegate, Leonard V. Phillips; Alternate Delegates, Paul L. Weygandt, Jess F. Bond, James H. Pollock; H. Thomas Baumgardner, Francis J. Waickman; Trustee of the SCMS, Insurance Fund, E. L. Mollin.

The retiring secretary, Thomas F. Ulrich, M. D., assumes the editorship of the society bulletin.

The society membership has adopted a resolution to begin action on the purchase or construction of a society building for permanent headquarters of its business and professional functions.

The Summit County Medical Society has established an employment bureau for the convenience of its members in procuring office personnel. The employment service has been operating very successfully under the Member Service Bureau since September 1, 1961.—T. F. Ulrich, M. D., Secretary.

### TRUMBULL

The annual Christmas dinner and joint meeting of the Trumbull County Medical Society and Auxiliary was held on December 20 at Squaw Creek Country Club. Key civic leaders of the community were guests for the occasion.

New president of the Society is Dr. Thomas E. Wilson, who succeeds Dr. Charles M. Stone. He will be followed next year by Dr. Richard W. Juvanic. Dr. John Schlecht is secretary-treasurer.

## Ninth District

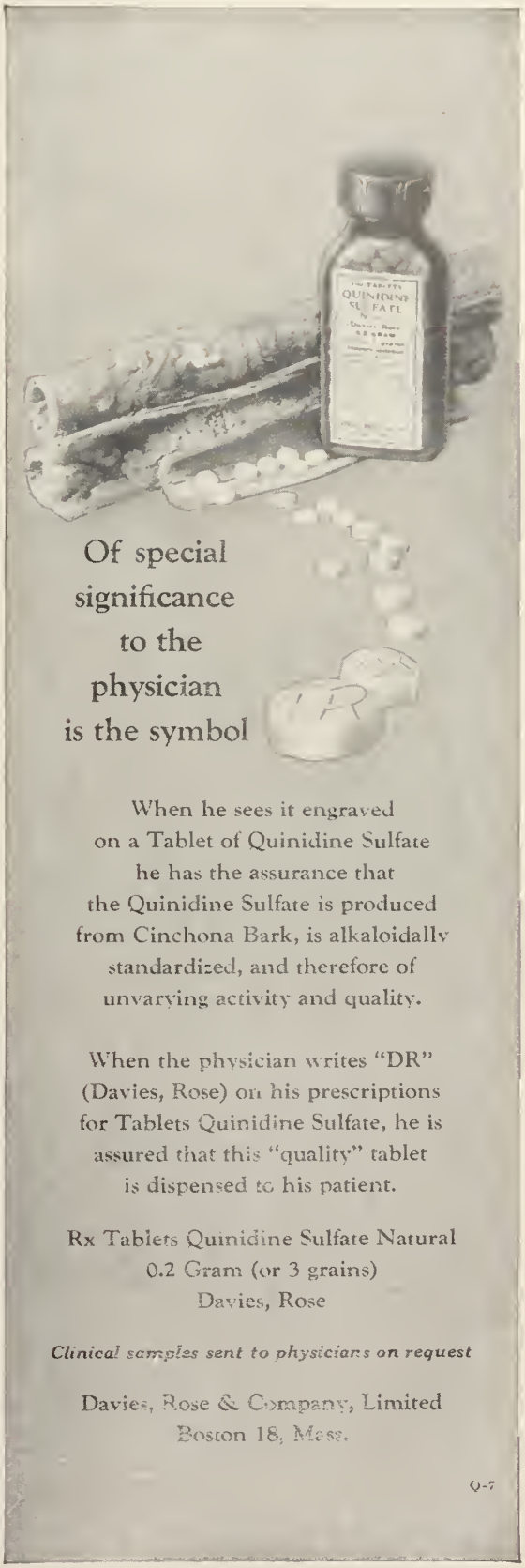
(COUNCILOR: CHESTER H. ALLEN, M. D., PORTSMOUTH)

### LAWRENCE

The Lawrence County Medical Society held an afternoon and evening program with dinner at the Boggs Coffee Shop, Ironton, on December 7. The following physicians spoke on the subjects indicated:

Dr. Edward Zenni, "Backache."

(Continued on Page 232)



*(Continued from Page 231)*

Dr. George Griffin, "Medical and Surgical Rx of Undescended Testicle."

Dr. Robert Matuska, "Diaphragmatic Hernia."

Seventeen members of the Society attended the meeting.

The annual Christmas Party, sponsored by the Auxiliary for Society and Auxiliary members was held on December 21 at the Patio in Ironton.

## Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

### ROSS

Dr. Howard E. Harman was honored at the annual Christmas party meeting of the Ross County Academy of Medicine, for his service in the profession, Dr. Robert Inglis, Columbus, Councilor of the OSMA Tenth District, presented the 50-Year Award.

Dr. Jack Tetirick, Columbus, was guest speaker and told of his experiences aboard the hospital ship "Hope." Dr. G. Howard Wood, president of the Society, presided.

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

One hundred persons attended The Lorain County Medical Society Annual Meeting and dinner which was a joint occasion with the Woman's Auxiliary at the Oberlin Inn on December 12.

Dr. Russell M. Arnold gave a Memorial Address for Dr. Valloyd Adair whose long years of service to his profession and community, as well as to the Lorain County Medical Society of which he was a past-president, made him an outstanding figure throughout the 58 years he was in practice.

Dr. Gabriel A. Sabga was elected to associate membership in the Society.

Reports of Committee Activity were submitted by the chairmen: Education—W. E. Kishman, M. D.; Grievance—R. D. Berkebile, M. D.; School Health—F. H. Schaefer, M. D.; Mental Health—Margaret R. Read, M. D.; Blood Bank—Roy E. Hayes, M. D.; Civil Defense—Ward Young, M. D.; Traffic Safety—James T. Stephens, M. D.; Liaison with County Welfare—R. A. DeMarco, M. D.; Legislative—James T. Stephens, M. D.; Tumor Registry—R. G. Thomas, M. D.

Dr. C. T. Rusin, 1961 president, was given a standing vote of thanks by his colleagues for his leadership and devotion to the Society's interests, and his report and that of the Secretary-Treasurer, Ward Young, Jr., were presented.

As chairman of the Nominating Committee, Harold E. McDonald, M. D., announced the slate of officers for 1962, and the following were elected: President—Roy E. Hayes, M. D. (Elyria); Vice-President—J. R. Bay, M. D. (Oberlin); President-Elect—Henry E. Kleinhenz, M. D. (Lorain); Secretary-Treasurer (re-elected)—Ward Young, Jr., M. D. (Elyria).

Delegates to OSMA for next 2 years: James T. Stephens, M. D. (Oberlin); John W. Newman, M. D. (Avon Lake). Serving as alternates: D. E. Harrison, M. D. (Elyria); John Halley, M. D. (Vermilion).

Elected to Board of Censors for a three year term: C. J. Cooley, M. D. (Oberlin).

Dr. L. C. Meredith, Eleventh District Councilor, commended the membership on its activity and reported on the AMA meeting in Denver and the various activities within the State.

* * *

Fifty physicians and five guests attended the first regular meeting of Lorain County Medical Society for 1962 at the Oberlin Inn. Following the social hour and dinner President Roy E. Hayes, M. D., conducted a brief business meeting.

Dr. John W. Adrain of Lorain was elected to Honorary Membership in the Society on his retirement from active practice. Dr. Y. S. Rida was elected to Active Membership.

Following the prescribed announcements and notices an amendment to the bylaws was unanimously approved, to read "Dues for the Society shall be such as is recommended by Council on approval of two-thirds of active members voting."

Donation of $25.00 was given to assist with the formation of the Lorain County Medical Assistants Society and physicians were urged to encourage their assistants to join.

The Medical Society, following its previous activity in organization for Disaster Planning, will stage a Mock Alert as a major program this year.

Sociology Professor Raymond Mack of Northwestern University will be the speaker at the March meeting. Physicians' wives and other guests will be invited.

Dr. Hayes further outlined his plans for committee activity in 1962. Every other meeting of the Society will be a business meeting, and that same evening, prior to the social hour, all committees will meet at the Oberlin Inn — thus obviating the necessity for additional evening meetings. Committees have been set up on a three-year rotating basis.

Dr. L. C. Meredith, Councilor of the Eleventh District, was present and brought pertinent matters to the attention of the group.

The program of the evening was a panel dealing with the new law permitting physicians to incorporate and so secure tax savings and other benefits. Under the title "Physicians Incorporated" Mr. Paul Rampe, consultant, served as moderator, and presented the following:

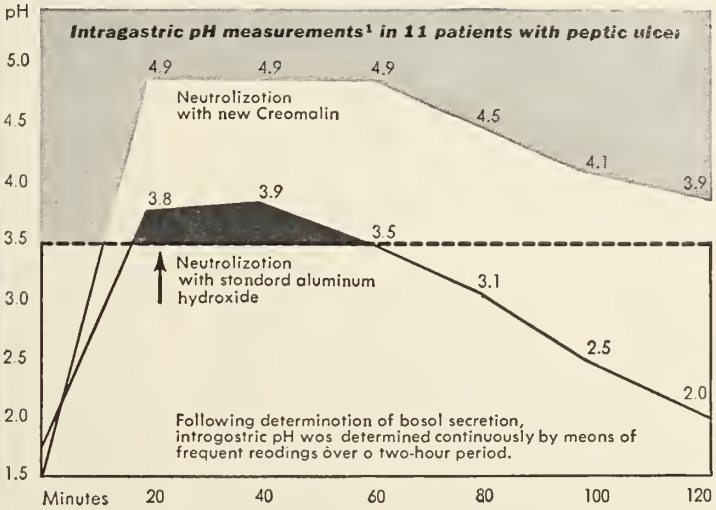
"Organization and Non - Tax Benefits" — Paul Rampe.

*(Continued on Page 234)*

# Acts as well in people as in test tubes

*in vivo*
*neutralizes*
*40 to 50 per cent*
*faster—*
*twice as long at*
*pH 3.5 or above*






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## Antacid Tablets

*Buffers fast*[1,4] for fast relief of pain—
takes up more acid

*Heals ulcer fast*—action more prolonged *in vivo*

*Has superior action of a liquid, with the convenience of a tablet*[5]

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. New Creamalin tablets are pleasant tasting and smooth, not gritty. They do not cause constipation or electrolyte disturbance.

*Dosage:* Gastric hyperacidity—from 2 to 4 tablets as needed.
Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours.

*How Supplied:* Creamalin Tablets, bottles of 50, 100, 200 and 1000.
Also available: New Creamalin Liquid (1 teaspoon=1 tablet),
bottles of 8 and 16 fl. oz.

*References:* **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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New York 18, N.Y.

**FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY**

(Continued from Page 232)

"Tax Benefits of Incorporation" — George Paul, Asst. Administration Officer, Internal Revenue Service.

"Law of Corporations"—Roman Gruber, Attorney.

"Trust Provisions in a Formal Document and These Provisions Related to Physicians"—James Herbert, President, Lorain National Bank.

Discussion followed, with Questions submitted from the floor.

### RICHLAND

The November meeting of the Richland County Medical Society was held at the Lex Lounge in Mansfield November 16 with Dr. J. O. Ludwig presiding. A social hour was held from six to seven. Dr. Lawrence Meredith, District Councilor, and the Resident Staff of Mansfield General Hospital attended as guests of the County Society.

A talk was given by Dr. Dan L. Urschel of Mentone, Indiana, an officer of the Flying Physicians Association. He discussed complications of air travel with special emphasis on cardiac complications. Considerable time was spent on the requirements of jet travel and space travel and the strains placed on the heart by this type of transportation. He stated that all practitioners are confronted by their patients with the problem of "will I be able to take this trip on a certain type of aircraft." He discussed the pressurizing of the cabins, but more important was the fact that the number of steps they had to climb in order to board a jet plane was a good indication of their ability to travel. He stated that anyone who could climb the steps to get into the plane without dyspnea or angina could make the trip in the plane. This is the general rule which the airlines have given their stewardesses. The talk was enjoyed by everyone and following the talk there was a question and answer period, after which the meeting was adjourned.

The annual "Rabbit Dinner" of the Richland County Medical Society was held at the Lex Lounge December 7.

A report of the recent Blue Cross - Blue Shield meeting was read by Dr. A. H. Voegele who represented our group. Recent changes in the Blue Cross - Blue Shield coverage were presented to the group.

Dr. Robert Ellison presented a proposal for the establishment of a clinic for all women in the community to attend. This would provide pelvic examination and a routine Papanicolaou smear. He requested the County Society to approve this in order that he may apply for State funds to conduct the clinic. The matter was discussed by members of the County Medical Society, pro and con, and finally a committee was appointed to study and report at a later date.

Dr. A. M. Duff, the co-chairman of the Civil Defense Committee, attended the Chicago meeting in early November and reported. He stated the meeting concerned itself with general topics, and not with the details of administration. Generally, the concensus of opinion was that fall-out shelters should be on a community basis and it was stressed that not enough attention had been paid to bacteriological and chemical warfare. The problem of fall-out shelters, to the present time, had not concerned itself with the elimination of noxious gases and poisons which would be in the air. It was stressed that filters are now developed but not in production which might be used in connection with this problem.

The report of the Nominating Committee was read and a slate of Officers for the following year, 1962, was approved as follows:

President, Dr. C. Karl Kuehne; Vice-President, Dr. Carl M. Quick; Secretary-Treasurer, Dr. Carroll E. Damron; Delegates, Dr. James O. Ludwig and Dr. William R. Roasberry; Alternate Delegates, Dr. R. E. Frush and Dr. C. F. Curtiss.

Dr. James O. Ludwig was appointed to the Advisory Committee. The vote was by acclamation and the new Officers were scheduled to take office January 1, 1962.—Carl M. Quick, M. D., Sec'y.

### WAYNE

Dr. Grant Stitzinger of Wooster was elected president of the Wayne County Medical Society at a dinner at the Town and Country Inn (Wooster).

Serving with him during the coming year will be the vice-president, who automatically is president-elect, Dr. Edward Gatz, of Shreve.

Secretary-treasurer is Dr. Richard Watkins of Wooster, and delegate to the Ohio State Medical Association is Dr. A. Burney Huff. His alternate is Dr. John Robinson.

The medical men named Dr. Howard MacMillen as new member of the local board of censors for a three year term.

Members of the society discussed plans for the use of the Sabin oral polio vaccine as a countywide project in public health protection.—*Wooster Daily Record.*

### How To Apply for Special "Physician" Auto Tags

Practitioners who would like the special automobile license plates marked "Physician," have until February 15 to apply for them. Here is the procedure to follow:

The applicant should write or apply to the Bureau of Motor Vehicles, 275 So. Fourth Street, Columbus 15, Attention, Reservation Department. He will be sent two forms. One is to be sent to the State Medical Board, 21 West Broad Street, Columbus 15, for certification. The second form is to be filled out by the applicant. When the certification form has been returned to the applicant, both forms should be presented to the local deputy registrar of motor vehicles, who will execute the forms properly and forward them to the Bureau of Motor Vehicles. The cost is $1 more than the regular license plate fee.

asthma attack averted
**. . . in minutes**

patient protected
**. . . for hours**





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(the dual-action anti-asthmatic tablet)

**. . . works with nebulizer speed—provides four-hour protection**

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# Activities of Woman's Auxiliary...

CHAIRMAN, PUBLICITY COMMITTEE — Mrs. F. M. Wadsworth, 35 Pinecrest, Mansfield, Ohio.
(Roster of Officers, Page 243)

### FRANKLIN

New officers were elected at the January 15 meeting at noon at The Maramor to serve the Woman's Auxiliary to the Academy of Medicine of Columbus and Franklin County in 1962-63.

The slate of nominees prepared by the nominating committee: Mrs. Norris Lenahan, chairman, and Mrs. Philip B. Hardymon, Mrs. A. L. Kefauver, Mrs. Robert Bohl, and Mrs. Rivington Fisher.

At this meeting, the speaker was Mrs. Ruth S. McCarthy, secretary of the Samuel and Engler Company, Columbus investment and brokerage firm. The topic of her speech was "Women and Investments." The program was arranged by Mrs. C. Robert McClave. Hostesses were Mrs. Richard Fulton and Mrs. Albert van Fossen. Mrs. Jack Bontley was in charge of reservations.

During December, instead of planning a meeting, members were guests of the Academy of Medicine at the annual banquet and dance on December 9 at Nationwide Inn. Decorations for the dance were arranged by Mrs. Arthur James, liaison chairman to the Academy; Mrs. Philip Hardymon, Mrs. Robert Murphy, Mrs. Henry Wynsen, Mrs. A. L. Slivinski and Mrs. James Henry.

Preceding the dinner-dance, new and prospective members of the Auxiliary were entertained at a cocktail party at the home of Dr. and Mrs. Allan Korb. Mrs. Korb, membership chairman, was assisted by Mrs. Kenneth J. Chapman, co-chairman; Mrs. Roger Williams, Mrs. James Kauffman, and Mrs. William Porterfield, all committee members.

### HURON

Holiday greens decorated the home of Mrs. R. W. Higgins, Norwalk, where the Woman's Auxiliary to the Huron County Medical Society gathered for the December dessert meeting.

In observance of the Christmas Season the Auxiliary will present a gift to the Huron County School for Retarded Children.

A booklet "Scholarship and Financial Aid Available to Nursing Students," prepared by Ohio League for Nursing and Ohio Department of Health, will be placed in the library of senior high schools in the county by the Auxiliary and will be available to all interested students.

### HAMILTON

Mrs. Charles W. Hoyt, chairman of the Philanthropy Committee, recently announced continuation of the Auxiliary's annual custom of sending Christmas checks to Longview State Hospital and Hillcrest School for Girls. Especially appreciative was Mrs. Robinson of Hillcrest School for Girls. "Our needs are many and great," she wrote, "and your gift will be used for shoes, bus fares, and special entertainment for the girls."

"Medicine, Politics, and You," the topic of the Auxiliary's October meeting, aroused such widespread interest that the Legislative Committee is planning four informal workshops in February to answer questions arising in this year of crisis for the future of American medical practice. Mrs. George D. J. Griffin, chairman of the Legislative Committee, has announced that special emphasis will be placed on each member's responsibility in this vital situation at the luncheon meetings.

### LUCAS

November 14, the Woman's Auxiliary of Toledo and Lucas County held Guest Day Tea at the Academy Library Building. Speaker for the event was Mrs. Sylvia Earle, a journalist from Boston. She spoke about her five years spent in Holland part of which she was under contract with radio Netherlands doing a program in English and Dutch.

Autumn days were busy days. The United Appeal team under the chairmanship of Mrs. Jack Burnheimer met its contribution quota with a 104.5 per cent rating. On October 25, the annual Paramedical Recruitment Tea was held at the Academy Building. Mrs. Frederick Osgood is head of the Paramedical Recruitment Committee, and Mrs. Emidio Gaspari and Mrs. C. J. A. Paule were chairmen for the tea. Miss Mary Dillinger, Flower Hospital nursing student, was awarded this year's nursing scholarship from the Auxiliary. Mrs. Ben Saeli, fund raising chairman, and her committee are selling stockings to all and for all. Proceeds are to go to the American Medical Education Foundation.

December 7 three Auxiliary members travelled to Fort Hayes Hotel in Columbus to attend the conference on Civil Defense for women's organizations of the State of Ohio. Attending were Mrs. Edward Doerman, Mrs. Paul Bell, and Mrs. C. J. A. Paule, State Civil Defense chairman. Highlight of the meeting was the Civil Defense handbook entitled *A Challenge for Women* whose purpose is to serve women's organizations as a guide in training emergencies.

### VAN WERT

October 9, 1961 — Kenneth Kunze, Van Wert County Civil Defense chairman, and Robert Cryer, county radiological defense operator, presented an

informative program on "Radiological Defense." The radiological defense program, fallout conditions after a nuclear attack and the monitor system across the country were explained by film and discussion. This was a dinner meeting with 12 attending.

November 3, 1961 — Dr. Harold Lauer and Lyman Strong of Lima, presented scenic slides and motion pictures of a fishing and hunting trip in Alaska at the November meeting. Report was given on a district meeting at Findlay attended by 4 members. This was a dinner meeting attended by 11 members.

December 11, 1961 — Christmas dinner party attended by 13 members. Donations received for a Christmas basket for a needy Van Wert County family. Members participated in a gift exchange.

## Governor Replies by Letter To Journal Comment

The following letter dated January 9, from Governor DiSalle to Dr. Petznick, President of the Ohio State Medical Association (not editor of *The Journal*), was in answer to an In Our Opinion entitled "Suggest Governor Correct Oversight" published on Page 1412 of the December, 1961, issue of *The Journal* and pointing out that no physician was appointed to the Ohio Commission on Aging, despite the fuss which is being made over health and medical services for the aged:

George W. Petznick, M. D., Editor
The Ohio State Medical Journal
79 East State Street
Columbus 15, Ohio

Dear Dr. Petznick:

Thank you for the interest in the Ohio Commission on Aging, expressed in the December issue of your Journal. You are correct in stating that the question of health services for the aged is a "major problem."

The members of the Commission were selected as a citizen's lay committee rather than as individuals representing special groups. You will note there are no clergy or professional workers with the aging, both of which also have a special interest in older people, on the Commission.

Advisory committees and consultants whose competence in the field of aging would make their advice and counsel of value to the Commission will, no doubt, be appointed by the Commission on a statewide, as well as local basis. It is in this area that the medical profession can make a very worthwhile contribution.

Sincerely,

(Signed) MICHAEL V. DISALLE
Governor

## Residency Program in Psychiatry Announced by Hospital

The Fairhill Psychiatric Hospital, 12200 Fairhill Road, Cleveland, recently announced approval of a two-year residency program in psychiatry. Features of the program are affiliations in child psychiatry with Western Reserve University and in neurology with the Cleveland Clinic.

The hospital is operated under jurisdiction of the Ohio Division of Mental Hygiene. Dr. Ewing H. Crawfis is superintendent.





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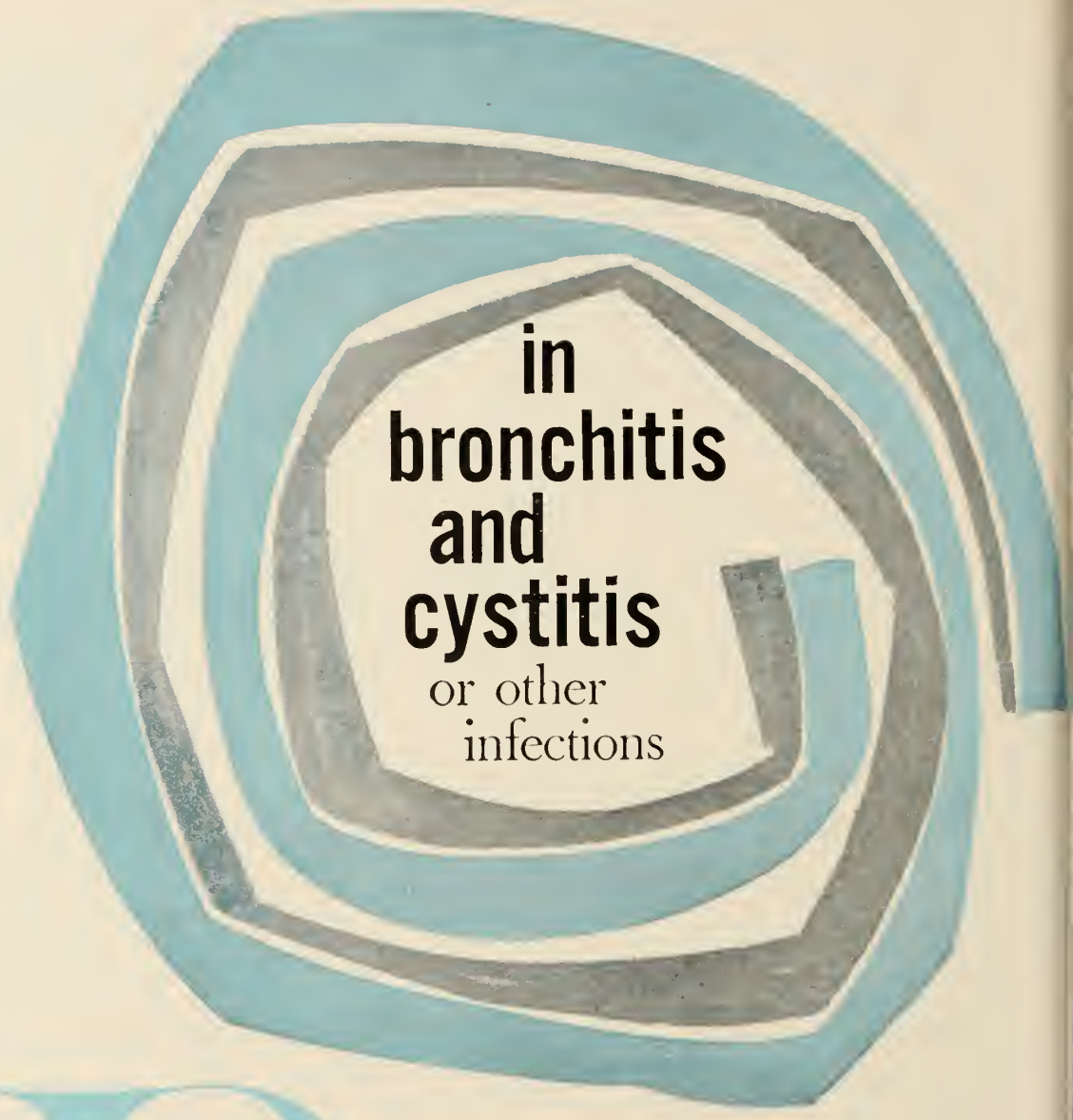
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1. **Exclusive Publication.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **Correspondence.** Address all correspondence relating to publication of scientific papers to: The Editor, The Ohio State Medical Journal, Room 1005, 79 East State Street, Columbus 15, Ohio.

3. **Manuscripts.** Manuscripts should be submitted in the original on standard 8½"x11" white typing paper. The entire text, including case reports and lists of references, should be typed double or triple space with margins of at least one inch on all sides. A copy of the manuscript should be retained by the Author.

4. **Tables and Charts.** Tables and charts that can be set in type may be included, and there will be no charge for their reproduction.

5. **Illustrations.** Illustrations requiring engraving (photographs, drawings, graphs, etc.) will be submitted to an engraver for an estimate of cost. *The Journal* will assume $25 of this expense and the Author will be billed directly by the engraver for the remainder.

Each illustration should bear the figure number and the author's name on the back. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints. Legends for the figures should be written on separate paper.

Used photographs and drawings will be returned after the article is published, if requested within 30 days after publication. Plates will be sent to the Author after the article has been published.

Obtaining permission for the taking and publishing of photographs is the responsibility of the author.

6. **References.** To conserve space and expense, lists of references should be limited to those essential to the subject and to which actual reference is made in the text.

References should be listed in the order of their appearance in the text.

Each reference should include, in this order: Author's last name and initials, title of the article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, month (day of month, if weekly), and year, e. g.

"2. Doe, J. Q., and Roe, R. X.: How to Go About It, Ohio State M. J., 13:24-30 (Feb.) 1920."

Authenticity and accuracy of references are the responsibilities of the Author.

7. **Identification of Patients.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

8. **Reprints.** An order blank for reprints with a table covering cost will be sent with the galley proof to the senior author.

Requests for reprints should be addressed to the Author.

9. **Editorial Assistance.** *The Journal* Staff is anxious to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as "Medical Writing — the Technique and the Art." by Morris Fishbein, M. D., Blakiston Division, McGraw-Hill Book Company, Inc., 330 West 42nd Street, New York 36, New York.

# County Societies' Officers and Meeting Dates

### FIRST DISTRICT

ADAMS—Hazel L. Sproull, President, West Union; Kenneth C. Jee, Secretary, Winchester. 3rd Thursday, January, April, July and October.

BROWN—Leslie Hampton, Jr., President, Sardinia Medical Clinic, Sardinia; Andrew J. Pasquale, Secretary, Route 2, Georgetown. 2nd Sunday, monthly.

BUTLER—James L. Sawyer, President, 2650 Stevens Ave., Medical Arts Bldg., Middletown; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. Last Wednesday of alternate months.

CLERMONT—Phillips F. Greene, President, Box 509, Rt. 1, New Richmond; Richard K. Lancaster, Secretary, 684 Batavia Pike-Vermona Drive, Cincinnati 45. 3rd Wednesday, monthly.

CLINTON—Foster J. Boyd, Jr., President, 291 N. South St., Wilmington; Emily B. Buchanan, Secretary, 255 Prairie Ave., Wilmington. 1st Tuesday, monthly.

HAMILTON—Edward Woliver, President, 2605 Burnet Ave., Cincinnati 19; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 2. 3rd Tuesday, monthly, September through May.

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WARREN—Ray E. Simendinger, President, 21 E. Main St., Lebanon; D. Paul Ward, Secretary, Pleasant Plain. 2nd Tuesday, monthly.

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MIAMI—Dale A. Hudson, President, 221 Orr-Flesh Bldg., Piqua; Jack P. Steinhilber, Secretary, 513 W. High St., Piqua. 1st Tuesday, monthly.

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MERCER—Charles P. Adkins, President, 217 S. Second St., Coldwater; R. Duane Bradrick, Secretary, 225 S. Main St., Rockford. 3rd Thursday, monthly.

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VAN WERT—Alford C. Diller, President, 113 N. Main St., Convoy; Donald W. Walters, Secretary, Home Guard Bldg., Van Wert. 1st Friday, monthly.

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### FOURTH DISTRICT

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FULTON—William J. Neal, President, 224 N. Defiance St., Archbold; Robert A. Gerrick, Secretary, 117 Edgewood St., Delta. 2nd Tuesday, quarterly.

HENRY—Raymond J. Manahan, President, 506 N. Perry St., Napoleon; Thomas F. Tabler, Secretary, 332 Railway Ave., Holgate. 1st Tuesday, monthly.

LUCAS—Crawford L. Felker, President, 1838 Parkwood Ave., Toledo 2; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly, except July & August.

OTTAWA—F. Kraft Ritter, President, 232 E. Second St., Port Clinton; V. William Wagner, Secretary, 122 E. Perry St., Port Clinton. 2nd Thursday, monthly.

PAULDING—Gaile L. Doster, President, 118 W. Jackson St., Paulding; John H. Schaefer, Secretary, Walnut & Perry Sts., Paulding. Called meetings.

PUTNAM—Joseph J. McHugh, President, Ottawa; Charles R. Kidd, Secretary, Kalida. 1st Tuesday, monthly.

SANDUSKY—Paul E. Burson, President, Corner Southwest & Center St., Bellevue; James B. Ball, Secretary, 113 West Main St., Bellevue. 3rd Wednesday, monthly.

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CUYAHOGA—John Dexter Osmond, Jr., President, 10515 Carnegie Ave., Cleveland 6; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 6. 3rd Friday, monthly.

GEAUGA—Kayoshi Masuoka, President, Medical Center, Chardon Plaza, Chardon; Raymond I. Smith, Secretary, P.O. Box 208, Chardon. 2nd Friday, monthly.

LAKE—Maxwell E. Burnham, President, 358 Bank St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor. 2nd Wednesday, monthly, of January, March, May, September and November.

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STARK—Graydon D. Underwood, President, Navarre Deposit Bank Bldg., Navarre; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., Canton 2. Second Thursday, monthly.

SUMMIT—Frank M. McDonald, President, 437 Ohio Building "B", Akron 8; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Bldg., Akron 8. 1st Tuesday, monthly.

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HARRISON—James Z. Scott, President, Main St., Box 512, Scio; George E. Henderson, Secretary, Main St., New Athens. Meetings held every three months.

JEFFERSON—Earl Rosenblum, President, 224 N. 4th St., Steubenville; Paul W. Ruksha, Secretary, 633 Lawson Ave., Steubenville. 2nd Tuesday, monthly.

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LICKING—Lawrence H. Miller, President, 205 S. Prospect St., Granville; James A. Quinn, Jr., Secretary, Newark Hospital, Newark. Last Tuesday, monthly.

## County Societies' Officers and Meeting Dates (Continued)

MORGAN—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta. Called Meetings.

MUSKINGUM—Rankin A. Nebinger, President, Third St., Roseville; Benjamin W. Gilliotte, Secretary, 821 Market St., Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, 510 West St., Caldwell; Edward G. Ditch, Secretary, 415 Main St., Caldwell. 1st Tuesday, monthly

PERRY—Sydney N. Lord, President, E. Main St., Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—C. A. S. Williams, President, 219 Fourth St., Marietta; Kenneth E. Owen, Secretary, 108 Gregg St., Marietta. 2nd Wednesday, monthly.

### NINTH DISTRICT

GALLIA—Norman W. Pinschmidt, President, The Gallipolis Clinic, Gallipolis; Thomas P. Price, Jr., Secretary, The Holzer Clinic, Gallipolis. Last Thursday, monthly.

HOCKING—John W. Doering, President, 42 N. Spring St., Logan; Howard M. Boocks, Secretary, Court House, Logan. Meetings held quarterly.

JACKSON—John L. Frazer, President, 16 N. Ohio Ave., Wellston; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called Meetings.

LAWRENCE—Ralph F. Massie, President, 408 Washington St., Ironton; George N. Spears, Secretary, 422 S. Sixth St., Ironton. Called meetings.

MEIGS—Selim J. Blazewicz, President, 112½ E. Main St., Pomeroy; Charles J. Mullen, Secretary, 210½ E. Main St., Pomeroy. Called Meetings.

PIKE—William W. Wiltberger, President, 330 E. North St., Waverly. 1st Tuesday, monthly.

SCIOTO—Spencer W. Miller, President, 1021 9th St., Portsmouth; William E. Daehler, Secretary, 1004 24th St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President and Secretary, McArthur.

### TENTH DISTRICT

DELAWARE—Lloyd Moore, President, Magnetic Springs; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

FAYETTE—Ralph Gebhart, President, 414 E. Court St., Washington C. H.; William L. Wead, Secretary, 1005 E. Temple St., Washington C. H. Last Tuesday, monthly.

FRANKLIN—Richard L. Fulton, President, 1211 Dublin Rd., Columbus 12; Mr. William Webb, Jr., Executive Secretary, 79 E. State St., Columbus 15. 3rd Monday, monthly, except May, June, July and August.

KNOX—Delbert C. Schmidt, President, 205 East Chestnut St., Mt. Vernon; Richard L. Smythe, Secretary, Medical Arts Bldg., Mt. Vernon. Usually 1st Wednesday, monthly.

MADISON—Sol Maggied, President, 15 E. Pearl, West Jefferson; Charles Terrill Hay, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

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ROSS—Robert E. Swank, President, 172 E. Main St., Chillicothe; David McKell, Secretary, 60 Central Center, Chillicothe. 1st Thursday, monthly, except June, July and August.

UNION—Walter R. Burt, President, West State St., Milford Center; May B. Zaugg, Secretary, 130 N. Maple St., Marysville.

### ELEVENTH DISTRICT

ASHLAND—Paul J. Sauder, President, 1109 Eastern Ave., Ashland; William H. Rower, Secretary, 1060 Claremont Ave., Medical Arts Bldg., Ashland. 1st Friday, monthly.

ERIE—Carl R. Swanbeck, President, 1218 Cleveland Rd., Sandusky; Donald B. Cuthbertson, Secretary, 421 Wayne St., Sandusky. Alternately, 3rd Tuesday & Thursday of the month.

HOLMES—Neven P. Stauffer, President, W. Adams St., Millersburg; Luther W. High, Secretary, 109 S. Clay St., Millersburg. 2nd Wednesday, monthly.

HURON—John V. Emery, President, Box 269, Willard; Nino M. Camardese, Secretary, 12 Benedict Ave., Norwalk. 2nd Wednesday, every other month.

LORAIN—Roy E. Hayes, President, Elyria Medical Arts Bldg., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 214 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Nevin J. M. Klotz, President, 162 Main St., Wadsworth; Leroy G. Dalheim, Secretary, 220 East Liberty St., Medina. 3rd Thursday, monthly, except July and August.

RICHLAND—C. Karl Kuehne, President, 480 Glessner Ave., Mansfield; Carroll E. Damron, Secretary, 30 S. Mulberry St., Mansfield. 3rd Thursday, monthly.

WAYNE—G. G. Stitzinger, President, 1800 Beall Ave., Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday, monthly.

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# Coming Meetings . . .

American Medical Association, Annual Meeting, Chicago, June 24-28.

Ohio State Medical Association, Annual Meeting, Columbus, May 14-18.

Central Surgical Association, Cincinnati, February 22-24.

Society of University Surgeons, Cleveland, February 8-10.

American College of Physicians, 43rd Annual Session, Philadelphia, April 9-15.

Ohio State Radiological Society meeting, Akron, May 25-27, Chapin Hawley, M. D., Secretary, 927 Carew Tower, Cincinnati 2.

Ohio State University College of Medicine, Anesthesia Seminar, Anesthesia Division, Department of Surgery, February 23-24.

University of Cincinnati College of Medicine, Annual Samuel Freedman Lecture in Diagnostic Radiology, April 28, 29.

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*References:* (1) Malone, F. J., Jr.: *Mil. Med.* 125:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* 34:187, 1959. (3) Ullman, A.: *Delaware M. J.* 32:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* 108:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* 10: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* 11:392, 1960.

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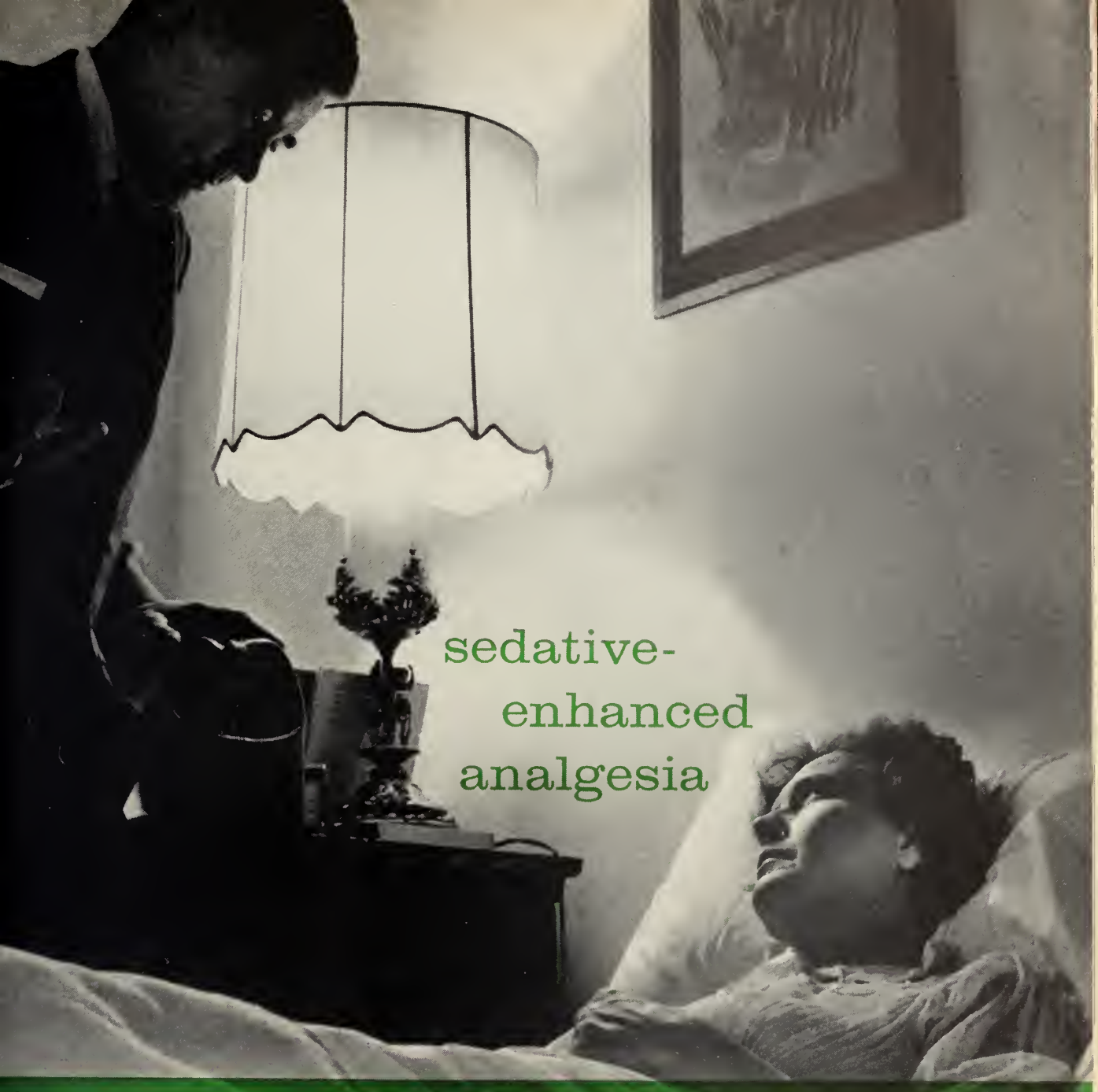
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Bottles of 100 and 500 capsules.

1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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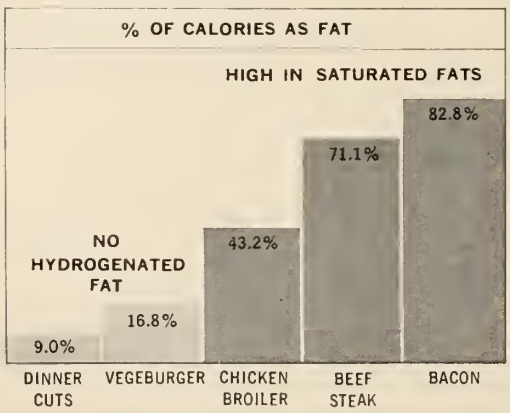
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**Controls food craving, keeps the reducer happy** — In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West.J.Surg. 59:238 (May) 1951.

# 'METHEDRINE'®

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Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

Literature available on request.

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# blood pressure approaches normal more readily, more safely....simply with Salutensin®

(hydroflumethiazide, reserpine, protoveratrine A–antihypertensive formulation)

**Early, efficient reduction of blood pressure.** Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"[1]) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents[2-8] provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron® (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide[9]; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

**Added advantages for long-term or difficult patients.** Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide/rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

**Each Salutensin tablet contains:** 50 mg. Saluron® (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

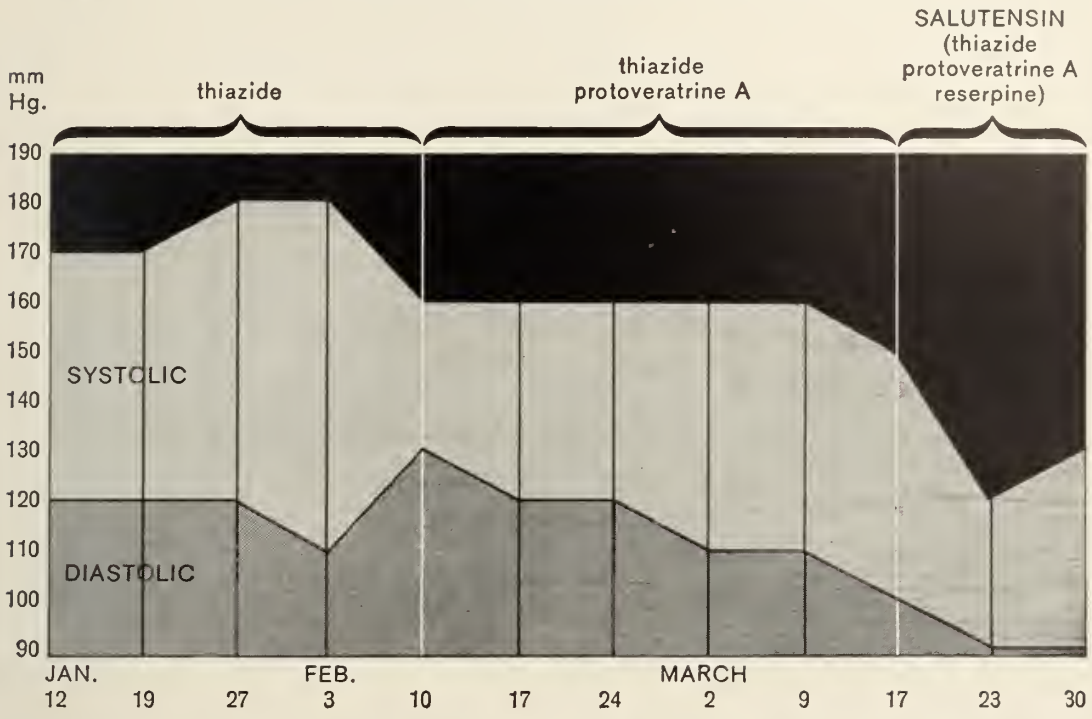
**Supplied:** Bottles of 60 scored tablets.

**References:** 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

## all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific, physiologic vasodilation of protoveratrine A

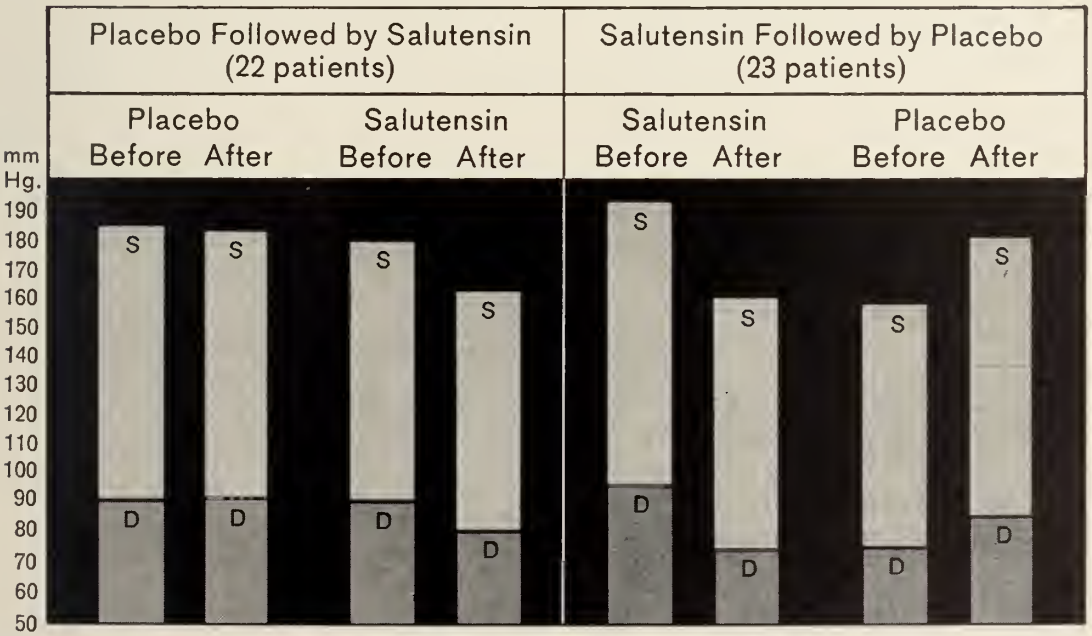
**11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE**

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)




**3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY**

Mean Blood Pressures–Systolic (S) and Diastolic (D)

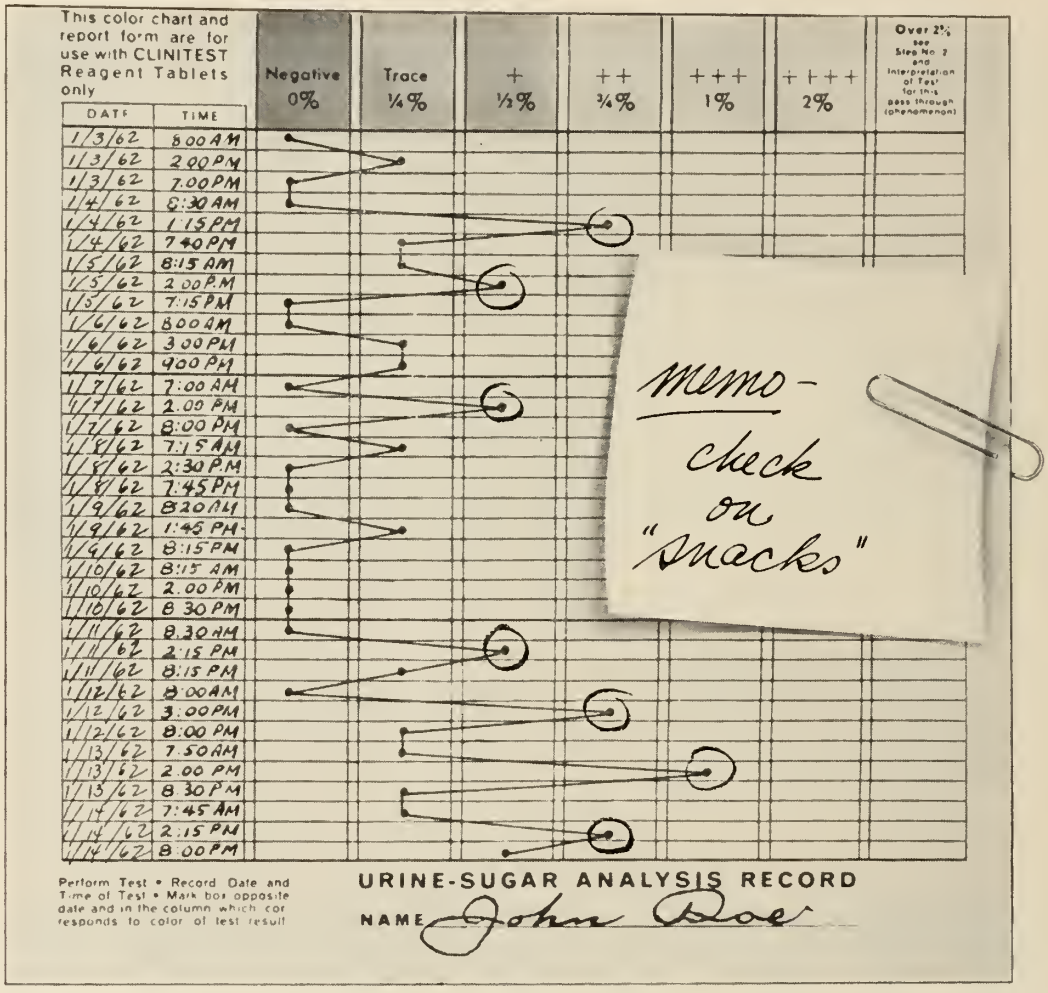



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

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## CLINITEST® BRAND *Reagent Tablets*

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The reason, of course, is Filmtab coating. Unlike previous sugar coatings, no water is needed for application. This virtually eliminates chances of moisture degradation.

Greater stability, however, is just one of Optilets advantages. Without sugar's bulk, we can make tablets up to 30% smaller in size. Coatings are less brittle, and tablets less apt to chip or break. As Filmtab coatings are no more than paper-thin, nutrients are more readily available. Yet, patients are protected from vitamin odors and after-tastes.

While stability is important and easy administration an advantage, ingredients are, of course, the main criteria for any nutritional. Please check the Optilets formulas, doctor. We think you'll find them a good choice for your patients.

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| Vitamin A | 7.5 mg. (25,000 units) |
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| Nicotinamide | 100 mg. |
| Pyridoxine Hydrochloride | 5 mg. |
| Cobalamin (Vitamin $B_{12}$) | 6 mcg. |
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| Iodine (as calcium iodate) | 0.15 mg. |
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| Manganese (as sulfate) | 1 mg. |
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| Zinc (as sulfate) | 1.5 mg. |
| Molybdenum (as sodium molybdate) | 0.2 mg. |




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"All the world's a stage..
And one man in his time
plays many parts,
His acts being seven ages..."*

*As You Like It, Act II, Sc. 7

through all seven ages of man

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## effective anxiety control with a wide margin of safety




**in the "frantic forties"**—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

In each of these areas, VISTARIL is often effective alone or as an adjunct to other therapy. For example, in his series of 67 patients, King[1] found that 62 showed remission of anxiety, tension, nervousness and insomnia, as well as alleviation of symptoms associated with various functional and psychophysiological disturbances. He concludes that VISTARIL is well suited for use in the practice of internal medicine.

In the emergent situation, VISTARIL, administered parenterally, is a valuable aid to the physician in managing patients who escape psychic conflict via alcohol. According to Weiner and Bockman,[2] who obtained beneficial results in 81% of 175 patients studied, hydroxyzine (VISTARIL) may well be considered a tranquilizer of choice in the management of the acutely agitated alcoholic.

1. King, J. C., Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A. Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

VISTARIL® CAPSULES AND ORAL SUSPENSION
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HYDROXYZINE HYDROCHLORIDE

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**See "IN BRIEF" on the next page**

IN BRIEF VISTARIL®

VISTARIL, hydroxyzine pamoate (oral) and hydroxyzine hydrochloride (parenteral solution), is a calming agent unrelated chemically to phenothiazine, reserpine, and meprobamate.

VISTARIL acts rapidly in the symptomatic treatment of a variety of neuroses and other emotional disturbances manifested by anxiety, apprehension, or fear—whether occurring alone or complicating a physical illness. The versatility of VISTARIL in clinical indications is matched by wide patient range and a complete complement of dosage forms. The calmative effect of VISTARIL does not usually impair discrimination. No toxicity has been reported with the use of VISTARIL at the recommended dosage, and it has a remarkable record of freedom from adverse reactions.

**INDICATIONS:** VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

**ADMINISTRATION AND DOSAGE:** Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

**SIDE EFFECTS:** Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

**PRECAUTIONS:** Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

**SUPPLIED:** VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

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## Step-Up Noted in Medical Education Facilities

The sharp warnings issued by well-known medical educators that we must rapidly increase the number of medical school graduates and establish at least 20 new schools in order to produce 3,600 additional physicians a year by 1975 in order to maintain the present physician-population ratio, are beginning to yield some tangible results.

Rutgers and Brown Universities have announced plans are underway to offer two-year programs in the basic medical sciences.

The University of New Mexico is fast making strides toward starting a two-year program in the basic medical sciences by appointing as dean, Dr. Reginal H. Fitz, associate dean of the University of Colorado School of Medicine.

San Antonio, Texas, won a long-sought drive to locate a medical school in that city recently when a deed for 100 acres of land for the school was presented to the University of Texas. Formal ceremonies dedicating the grounds to the construction of a medical center were held Aug. 19 with Dr. Joseph C. Hinsey, director of the New York-Cornell Medical Center being one of the principal speakers. The state legislature has appropriated $1.85 million to begin the medical school.

While states such as Maine, Massachusetts, Michigan, Minnesota, Idaho, Ohio, and New York are studying the possibilities of establishing new medical schools, the Connecticut Legislature went into action by appropriating $2 million to help start a new medical-dental school to be affiliated with the University of Connecticut. The amount, coupled with a $1 million grant from the Kellogg Foundation, will enable the university to actively start work on the four-year medical school.

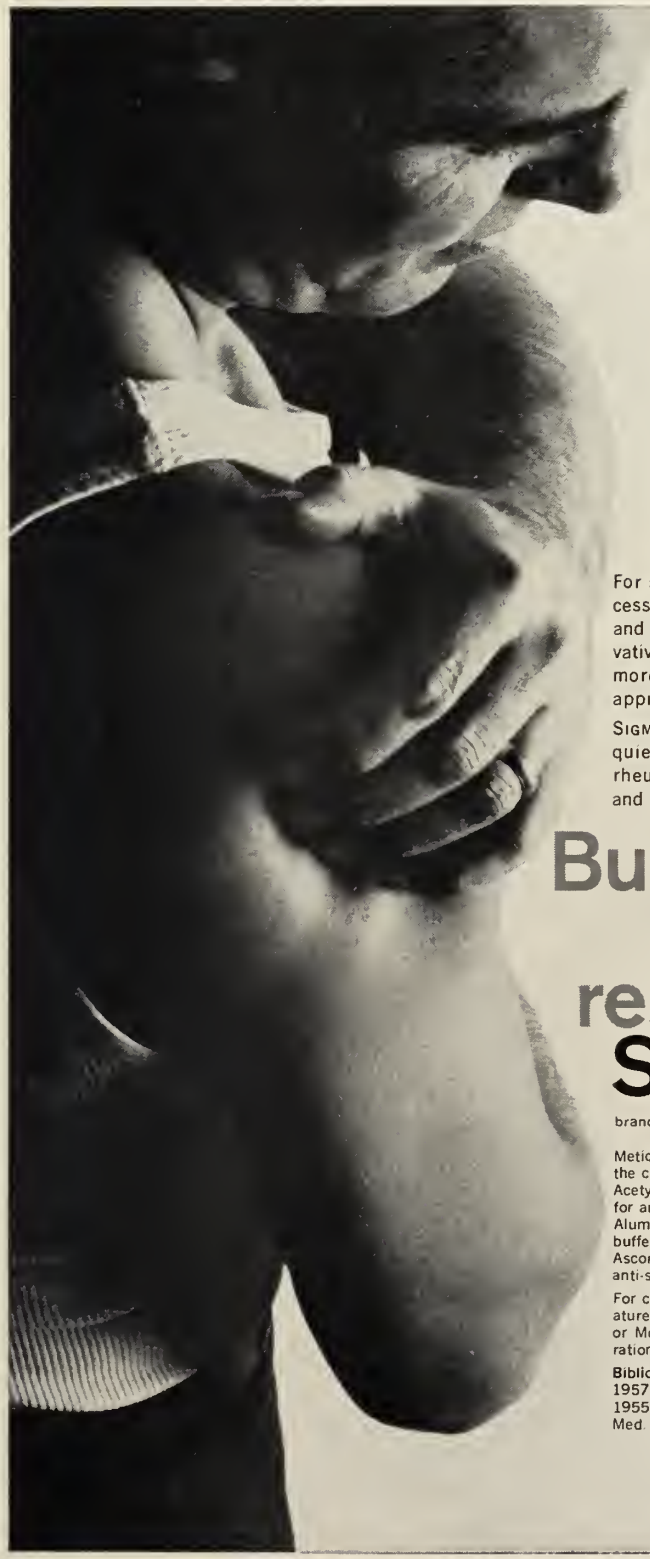
The University of Arizona has been selected by the Board of Regents as a medical school site, "if and when funds are available."

Latest reports from California reveal that the Board of Regents of the University of California have under serious consideration plans for a four-year medical school for the proposed new university campus at San Diego. — *Association of American Medical Colleges Newsletter.*

## Rules on County Liability In Accident Cases

A board of county commissioners has no authority to spend public funds to pay hospital bills, unless the person is indigent, or needy and permanently and totally disabled, or confined in jail, according to an opinion given by Attorney General Mark McElroy.

The opinion was given in response to a question as to whether the county could be held liable for hospital bills of a person who had been brought to the hospital by the sheriff after an accident.



For seven years SIGMAGEN has been successfully used in the treatment of bursitis and myositis. SIGMAGEN provides a conservative, in-between level of therapy — far more capable than analgesics, yet not approaching high steroid dosage levels.

SIGMAGEN will swiftly allay the pain and quiet the inflammatory process in mild rheumatoid arthritis, bursitis, myositis and fibrositis.

# Bursitis and myositis respond to Sigmagen®

brand of corticoid-analgesic compound

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For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, New Jersey.

**Bibliography: 1.** Cohen, A., et al.: J.A.M.A. 165:225, 1957. **2.** Spies, T. D., et al.: J.A.M.A. 159:645, 1955. **3.** Moravec, C. L. and Moravec, M. E.: Clin. Med. 7:2322, 1960. H-416

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satisfactory results in 88% of cases

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**comments:** "Scaling disappeared, and... the skin became softer and smoother..." with Sardo.

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atopic dermatitis
senile pruritus
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nummular dermatitis
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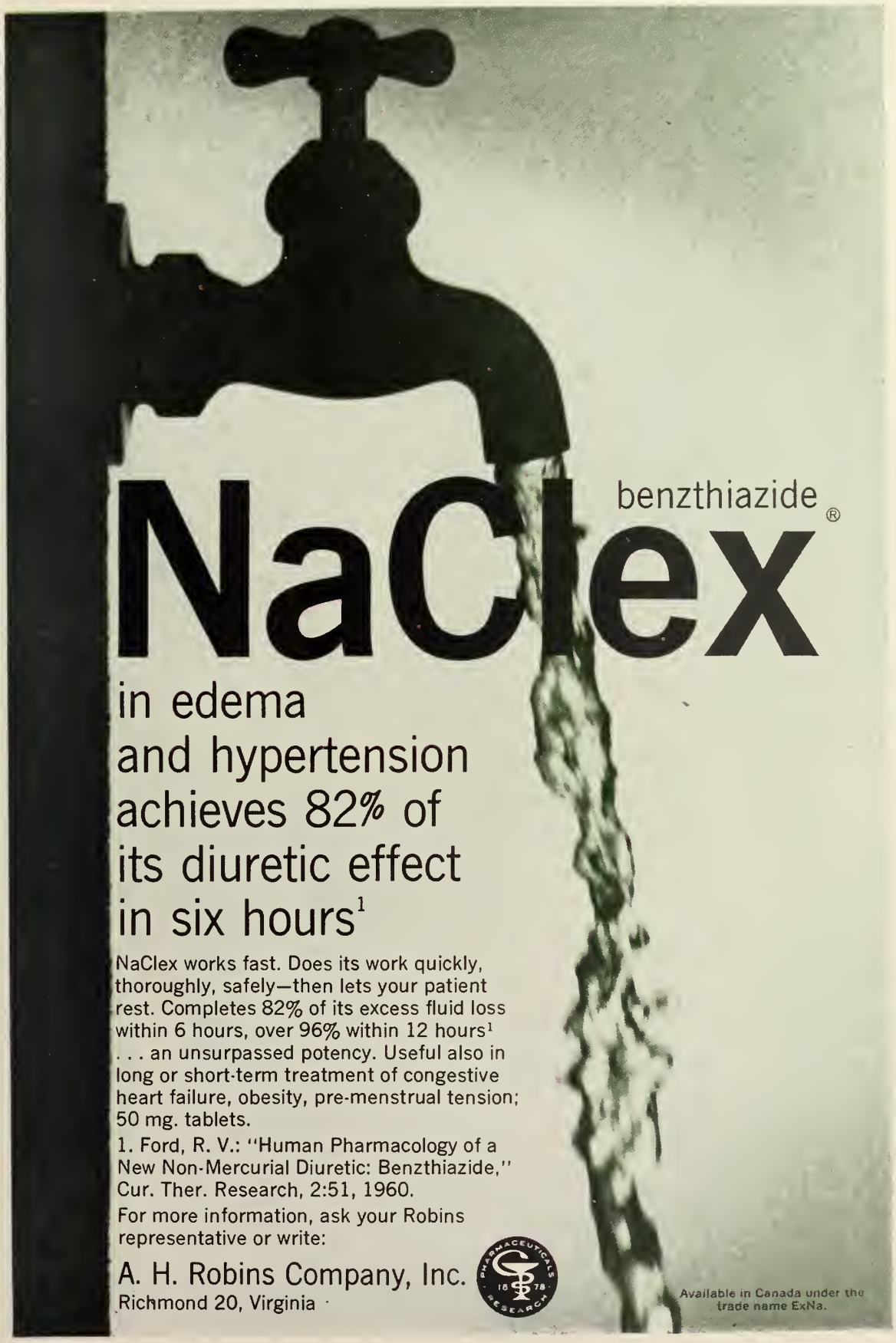
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achieves 82% of
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in six hours[1]
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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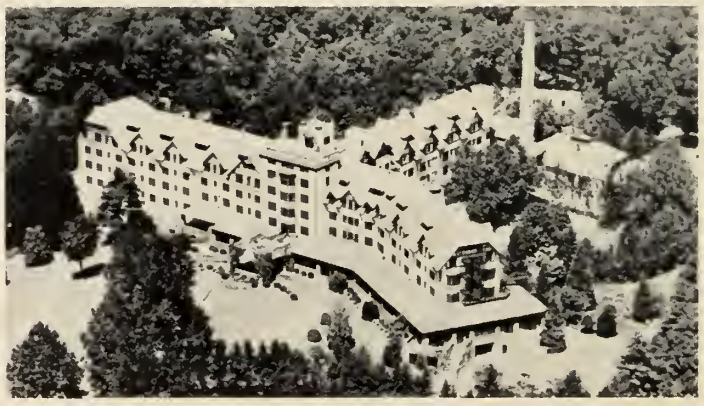
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These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

| Location | Facility | Telephone |
|---|---|---|
| Akron | Children's Hospital<br>W. Bowery and W. Bechtel | BL 3-5531, Ext. 246 |
| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
| Toledo | Toledo Health Department<br>635 N. Erie St. | CH 4-1961—(Day)<br>EV 5-4661—(Night) |


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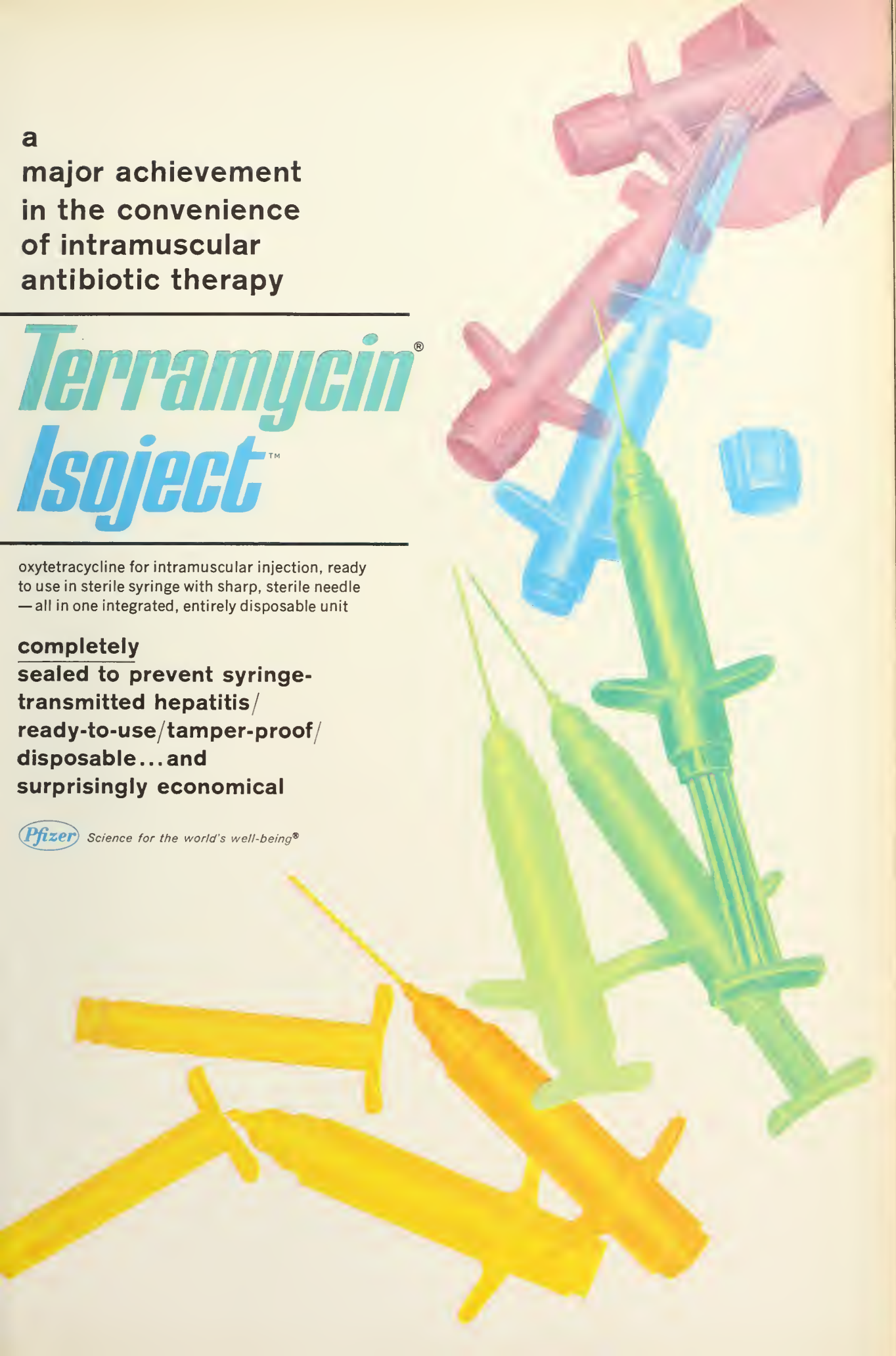
**a**
**major achievement**
**in the convenience**
**of intramuscular**
**antibiotic therapy**

# Terramycin® Isoject™

oxytetracycline for intramuscular injection, ready to use in sterile syringe with sharp, sterile needle — all in one integrated, entirely disposable unit

**completely**
**sealed to prevent syringe-transmitted hepatitis/**
**ready-to-use/tamper-proof/**
**disposable...and**
**surprisingly economical**

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**a major achievement in the convenience of intramuscular antibiotic therapy**

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provides the benefits of Terramycin Intramuscular Solution: rapid effectiveness against a broad range of pathogens; rapid, wide distribution in body tissues and fluids; excellent toleration

## plus . . . all the advantages of the ISOJECT unit:

**convenient** completely self-contained/no intricate assembly/no chance of lost parts

**sterile and completely disposable** prevents syringe-transmitted hepatitis

**economical** compares very favorably in cost with less convenient and practical forms — and reduces likelihood of breakage and waste

**tamper-proof** unit is safely sealed

**presently available ISOJECT forms:**
Terramycin® Intramuscular Solution — 100 and 250 mg.
Vistaril® Parenteral Solution — 25 and 50 mg.
Streptomycin Sulfate Solution — 1 Gm.

**IN BRIEF**

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. As with all I.M. preparations, injection should be made within the body of a relatively large muscle. Care should always be taken to avoid injection into a major nerve or its surrounding sheath. For complete dosage, administration, and precaution information, read package insert before using. Terramycin Intramuscular Solution contains 2% (W/V) Xylocaine.*

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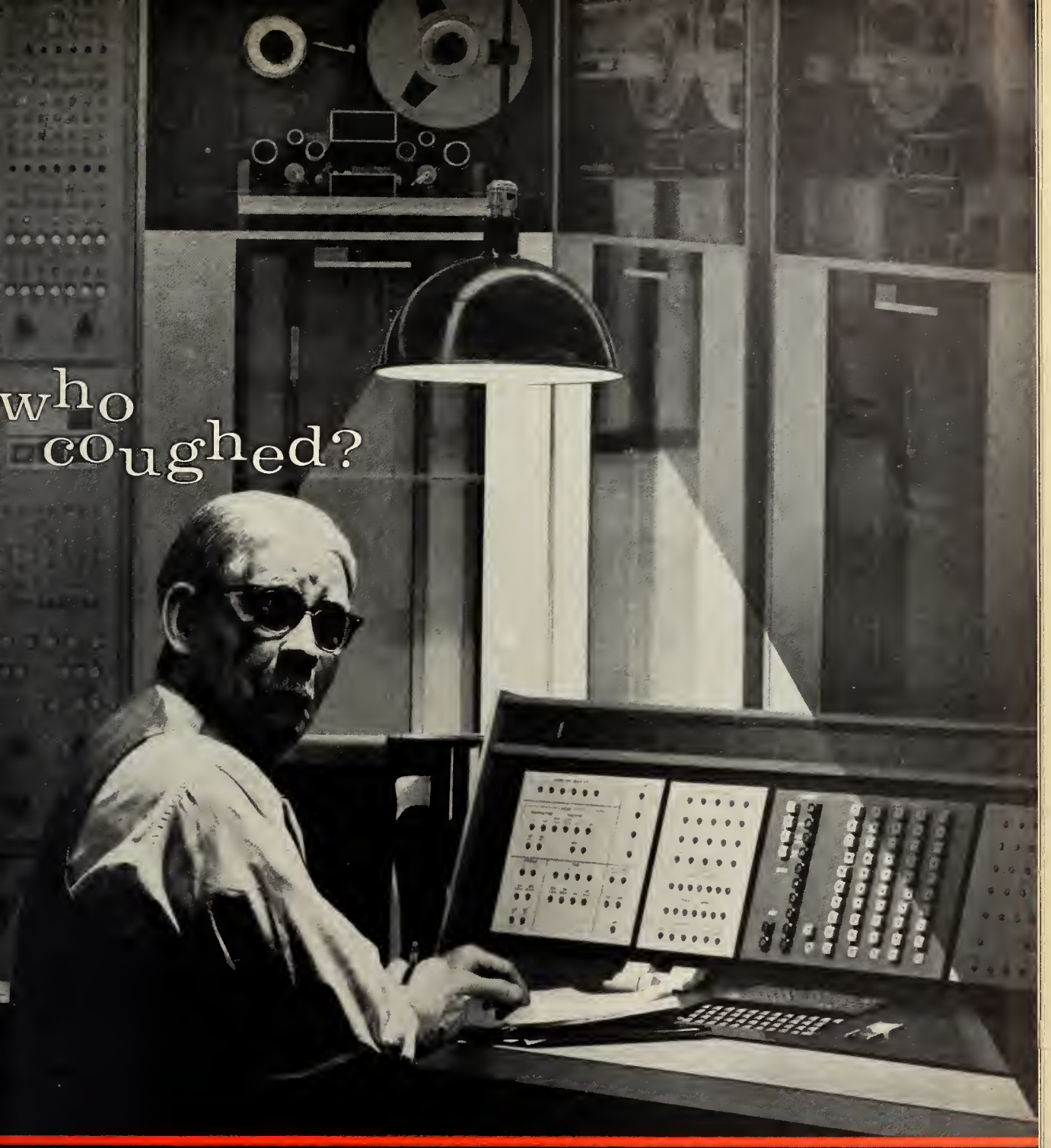
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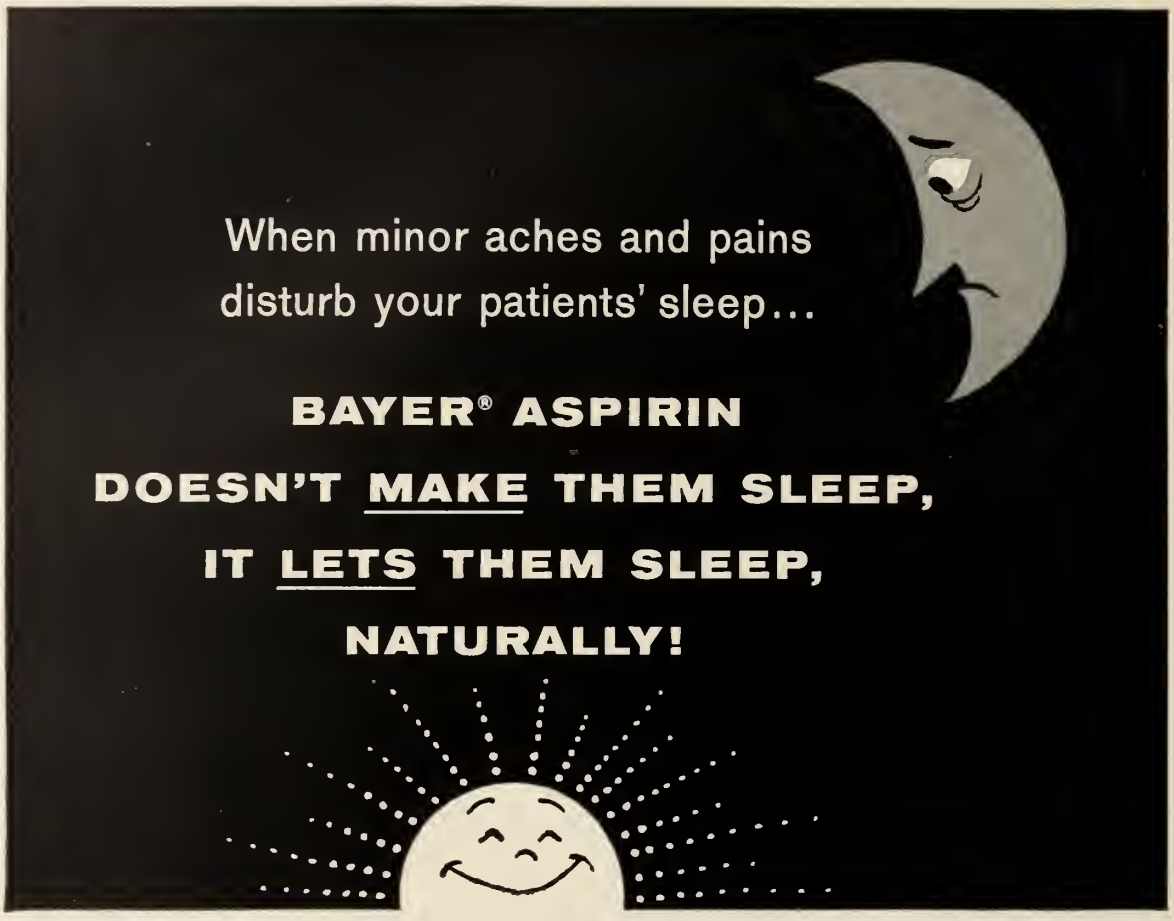
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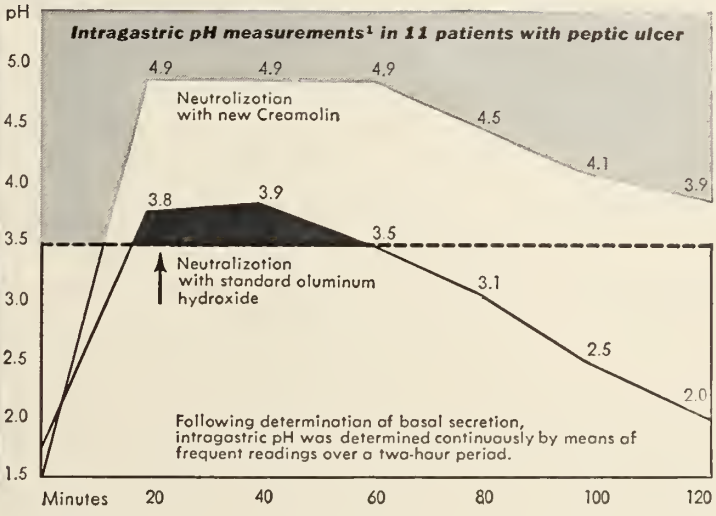
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*How Supplied:* Creamalin Tablets, bottles of 50, 100, 200 and 1000.
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*References:* **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

**cardiac diseases** "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

**arthritis** "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez Herlihy, L.: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

**digestive diseases** Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H. Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

**degenerative diseases** "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T. C. C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

**infectious diseases** Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

**diabetes** Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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In one of the most commonly used technics, an initial dose of 100 mg. of Demerol and 1/150 grain of scopolamine is given intramuscularly when labor is established. Subsequently, 100 mg. of Demerol are given every four hours and 1/200 grain of scopolamine every three hours. "Within 15 or 20 minutes the pain is relieved and neither the frequency nor the intensity of the uterine contractions are diminished."

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Demerol is "... an analgesic drug which relieves pain about as well as does morphine, and it has in addition an antispasmodic action which makes it a good preparation for use during labor. . . . It may be given alone but its effect is enhanced when it is used in combination with scopolamine, and the resultant amnesic effect is excellent."

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When Demerol with Scopolamine is used, idiosyncrasy to scopolamine may be encountered occasionally, producing the paradoxic effect of excitement, restlessness, hallucinations and delirium instead of sedation and amnesia. In addition, edema of the uvula, glottis and lips may be encountered occasionally in extremely hypersensitive patients.

Nalorphine (Nalline®) or levallorphan (Lorfan®) are considered to be specific antidotes against respiratory depression which may result from overdosage or unusual sensitivity to narcotics including Demerol.


1. Ranney, Brooks: *South Dakota J. Med. & Pharm.* 11:479, Dec., 1958.
2. Posner, L. B.; Fielding, W. L., and Posner, A. C.: *Obst. & Gynec.* 2:81, July, 1953.
3. Beck, A. C., and Rosenthal, A. H.: Obstetrical Practice, ed. 7, Baltimore, The Williams & Wilkins Company, 1958, pp. 1029, 1030.
4. Hershenson, B. B., and Reid, D. E.: *Bull. Narcotics* 8:36, July-Sept., 1956.
5. Titus, Paul: The Management of Obstetric Difficulties, ed. 5, St. Louis, C. V. Mosby Co., 1955, p. 617.


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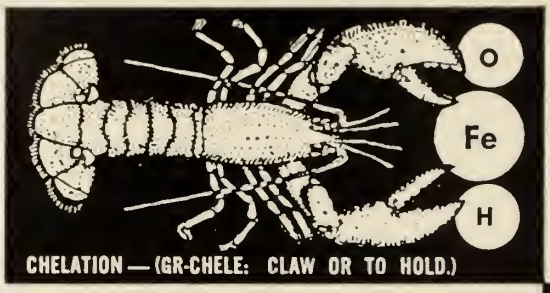
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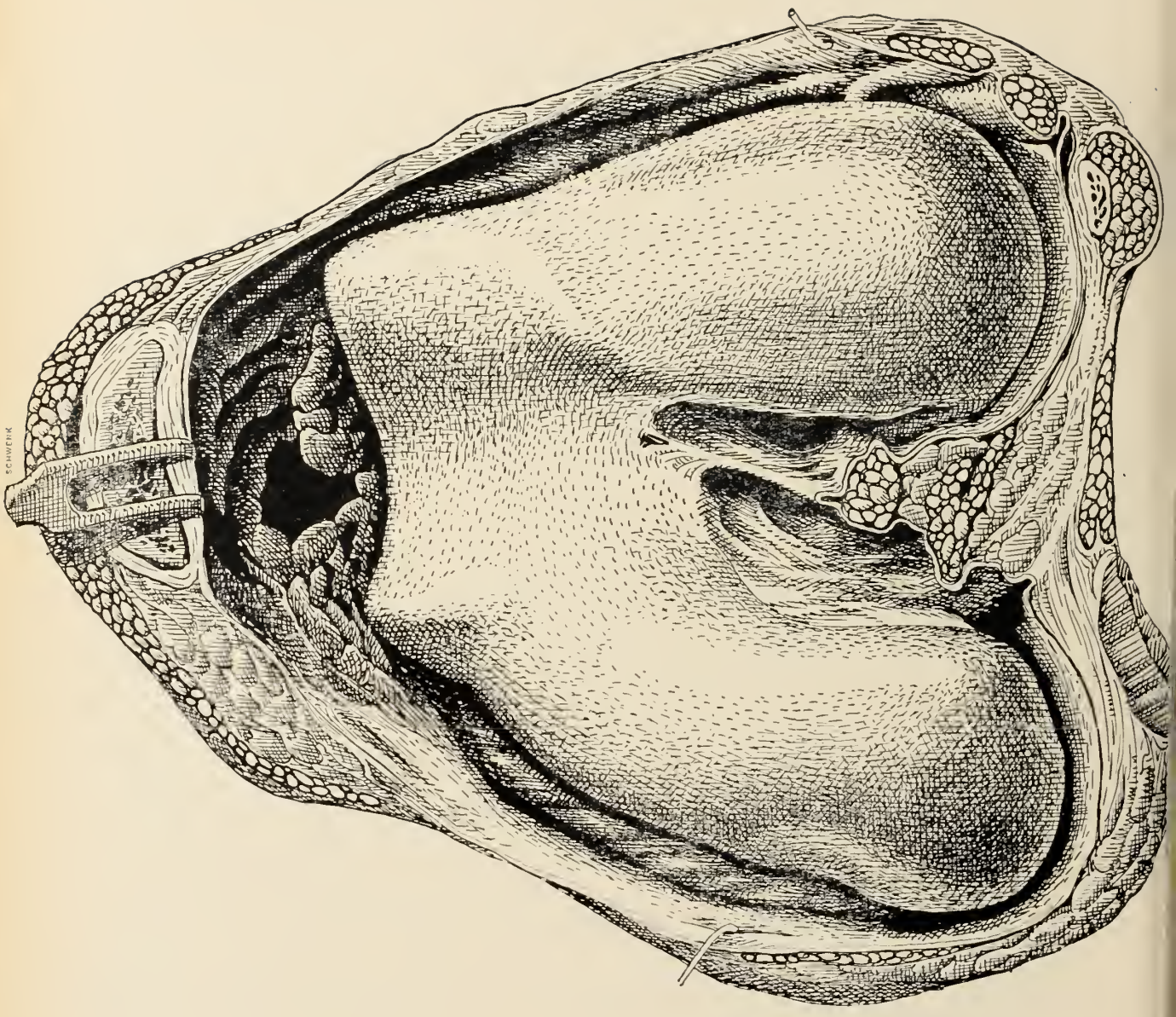
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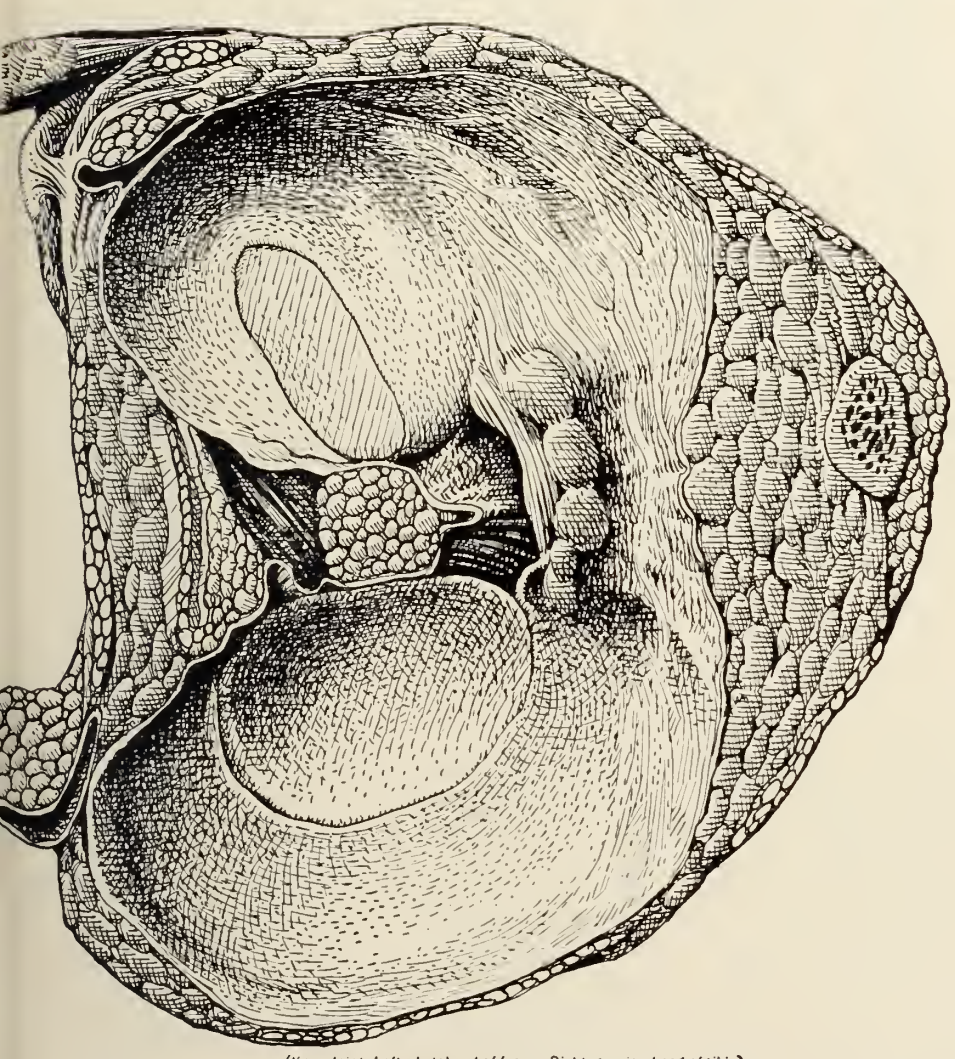
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# Scientific Exhibits, Lectures, and Manuscripts

## Two New Books Indispensable for Those Concerned with Dissemination Of Scientific Information

**Scientific Exhibits,** by Thomas G. Hull, Ph. D., and Tom Jones ($6.50, *Charles C. Thomas, publisher, Springfield, Illinois).* The modern scientific exhibit came into its own when in 1899 two physicians presented pathological specimens at the American Medical Association's meeting in Columbus, Ohio.

The physicians had previously made their exhibit available to the Indianapolis Medical Society and it was of such interest they obtained an empty storeroom located about a half block from the present headquarters of the Ohio State Medical Association and displayed the specimens on shelves and benches.

Said to be the first book in the scientific exhibit field, this work by Hull and Jones takes the prospective exhibitor through the stages of planning and designing the exhibit, construction, transportation to the convention, setting up, and the return trip home. Seventy illustrations assist the authors in bringing to the reader their 75 years of combined experience in this highly specialized work.

Dr. Hull is former secretary of the AMA Council on Scientific Assembly; Associate Professor of Preventive Medicine Emeritus, University of Illinois College of Medicine, and now executive director of medical exhibits at the Chicago Museum of Science and Industry. Mr. Jones, who died last November 18, was professor of medical and dental illustrations emeritus at the University of Illinois and chairman of the Medical Exhibits Committee at the Museum of Science and Industry.

**A Practical Outline for Preparing Medical Talks and Papers,** by Robert M. Zollinger, M. D., William G. Pace, III, M. D., and George J. Kienzle, B. A. ($1.95, *The Macmillan Company, 60 Fifth Avenue, New York 11, N. Y.)* Under cover of darkness, have you ever walked out of a medical meeting because the speaker's slides were so crowded with information as to be illegible or unintelligible? Have you been frustrated by indistinct and poorly labelled illustrations for medical lectures or articles? Have you lost interest in medical motion pictures because the surgeon's hands frequently obscured the field, the knot-tying was interminable, or comment and description were inadequate to maintain orientation? Have you laughed, then applauded when a slide was projected first upside down, then as a mirror image, and then correctly? Have you suffered embarrassment for a speaker whose enunciation and timing reflected inadequate preparation and rehearsal? If so, you may wish that the perpetrators of these errors had read this excellent manual, which contains a wealth of practical advice for the preparation of medical lectures and manuscripts.

The authors are to be commended for their attention to small technical details and for their concise presentation. In addition to comprehensive discussion of major topics, including Principles for Lantern Slides, Projection Screens, The Surgical Motion Picture, Presenting a Talk, Panel Discussion, and Medical Writing, they use the inside front cover for a check list of items headed "Preparing For Travel To and From Meeting" and the inside back cover for another list headed "Preparing for Visitors."

They leave very little to the imagination and almost no room for error.

**A Study of Medical College Costs,** by Augustus J. Carroll. ($1.50, *Association of American Medical Colleges, 2530 Ridge Ave., Evanston, Illinois.)*

**Mental Health in the United States: A Fifty-Year History,** by Nina Ridenour, introduction by Wm. C. Menninger, M. D. ($3.50, *Harvard University Press, Cambridge 38, Mass.)*

**The Principles and Practice of Refraction,** by G. H. Giles. ($17.50, *Chilton Company, Philadelphia 39, Pennsylvania.)*

**The Story of X-Rays from Röntgen to Isotopes,** by Alan Ralph Bleich, M. D. ($1.35, *Dover Publications, New York 14, N. Y.)*

**Minister and Doctor Meet,** by Granger E. Westberg. ($3.50, *Harper & Brothers, New York 16, New York.)*

**Memoirs of a Medico,** by Dr. E. Martinez Alonso. ($4.50, *Doubleday & Company, Inc., New York 22, New York.)*

**The Amazing World of Medicine,** by Helen Wright and Samuel Rapport. ($3.50, *Harper & Brothers, New York 16, New York.)*




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[1]Taub, S. J.: Management of Anxiety in Allergic Disorders—New Approach. To be published in Psychosomatics; [2]Cahn, B.: Experience with a New Tranquilizing Agent (Hydroxyphenamate). Ibid; [3]Bergal, M., Beck, C., Davis, O. F., and Sloan, N.: On Use of Hydroxyphenamate in Anxiety Associated with Somatic Disease. To be published; [4]Alexander, L.: Effect of Hydroxyphenamate on Conditional Psychogalvanic Reflex in Man. Supplement to Diseases of the Nervous System, Sept.,1961; [5]Cahn, B.: Effect of Hydroxyphenamate in Treatment of Mild and Moderate Anxiety States. Ibid; [6]Cahn, M. M., and Levy, E. J.: Use of Hydroxyphenamate (Listica) in Dermatological Therapy. Ibid. [7]Eisenberg, B. C.: Amelioration of Allergic Symptoms with a New Tranquilizer Drug (Listica). Ibid; [8]Friedman, A. P.: Pharmacological Approach to Treatment of Headache. Ibid; [9]Greenspan, E. B.: Use of Hydroxyphenamate in Some Forms of Cardiovascular Disease. Ibid; [10]Gouldman, C., Lunde, F., and Davis, J.: Clinical Trial of Hydroxyphenamate in Alcoholic Patients. Ibid; [11]Personal Communications to Medical Department, Armour Pharmaceutical Company.

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**SUPPLIED:** *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
*Exempt Narcotic. Available on Prescription Only.*

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The Historian's Notebook

# Medical Pioneers in Contraception

## I — Charles Knowlton, M. D., 1800-1850

BRUNO GEBHARD, M. D.*

*THE SENTENCE:* Three months at hard labor. *The Defendant:* Charles Knowlton, M. D., age 32. *The Corpus Delicti:* A pamphlet titled "Fruits of Philosophy or The Private Companion of Adult People," first published anonymously in 1832.

Who was this man who has been called the American father of birth control? The "Fruits," which have been out of print for many decades, were re-published from the 10th American edition, Boston, 1877, by the *Peter Pauper Press* in 1937, with an introductory notice by Norman E. Himes and with medical emendations by Robert Latou Dickinson. The reprint is dedicated to Robert L. Dickinson, reading "Courageous leader of his medical colleagues in an important but still-neglected branch of preventive medicine." No first edition of the "Fruits" is known to be extant.[2] We know about it only by the court record. There is one copy in the Harvard Library Treasure Room of the second edition. There were only two copies of the fourth edition, one at the Library of the New York Academy of Medicine and the other one in Himes collection, which by good luck is now my property. There were nine editions up to 1839, and in 1877 a tenth edition was published by subscription of a group of professors of the Harvard Medical School.

Charles Knowlton and Robert Latou Dickinson are the two milestones in a century of birth control movement in the United States. Knowlton's weapons were the spoken word, the pen and the public print. Dickinson, in addition, used the pencil, the drawing, the model — all, the visual arts. Both belong to the small group of physicians who gave leadership to a movement which has been carried by lay groups and as to that, mainly by women. In this country Margaret Sanger is the recognized leader. It was she who coined the words "birth control," used first in her radical periodical "The Women Rebel," in 1914.[3]

Charles Knowlton was the first American physician writing for the laity about the anti-conception art, which today we call "Family Planning."

Knowlton was born at Templeton, County of Worcester, Massachusetts, May 10, 1800. His English ancestors came to this country 20 years after the Mayflower landing. Up to his eighteenth year, Charles lived and worked at his father's farm, with two brothers. He describes himself at that age, as being 5 feet 11 inches tall, spindle-shanked, and a confounded, dull scholar. Even at the age of 30, he says of himself, "I am not half taught in common spelling and book lessons up to this day."[4] We have, unfortunately, no likeness of him at any age.

Knowlton in his youth was mentally depressed to the point of melancholia. During a period of three years he consulted 10 different doctors, took medicines regularly three times a day, as bark, wine, tincture of cantharides, iron preparation, balsam, opium, nitrate of silver, alum, vegetable astringents and blisters. We know of this from his autobiography which covers his life to the age of 29, published by his physician son-in-law, S. J. W. Tabor, "The Late Charles Knowlton, M. D."[5]

### Gloomy Youth

Knowlton attended New Salem Academy for one-half summer term of six weeks in 1818, taught school in the winter, went back to the Academy in 1819. At the age of 20, he saw no future for himself but the next year was the turning point. Near the Knowlton farm, a well-known mechanic, Richard Stuart, played in his spare time with a machine producing electricity. Charles Knowlton moved in with Stuart, became his patient and took daily electric shock treatments. He improved rapidly from his depression and gloom. It is very likely that the presence of six daughters in the Stuart family, all singers and dancers, helped in the recovery as on April 17, 1821, he married the eldest, 17 year old Tabitha.

### Opposed Malthus

In his "Fruits" and later on, he always recommended early marriage as a cure for the worries of young people, opposing Malthus, Owens and others, who suggested late marriage.

Knowlton entered what then was called the New Hampshire Medical Institution in 1822. He had to

*(Continued on Page 292)*

*Dr. Gebhard, Cleveland, is Director of the Cleveland Health Museum.

Presented at the Annual Meeting of The Ohio Academy of the History of Medicine, Granville, Ohio, April 22, 1961.



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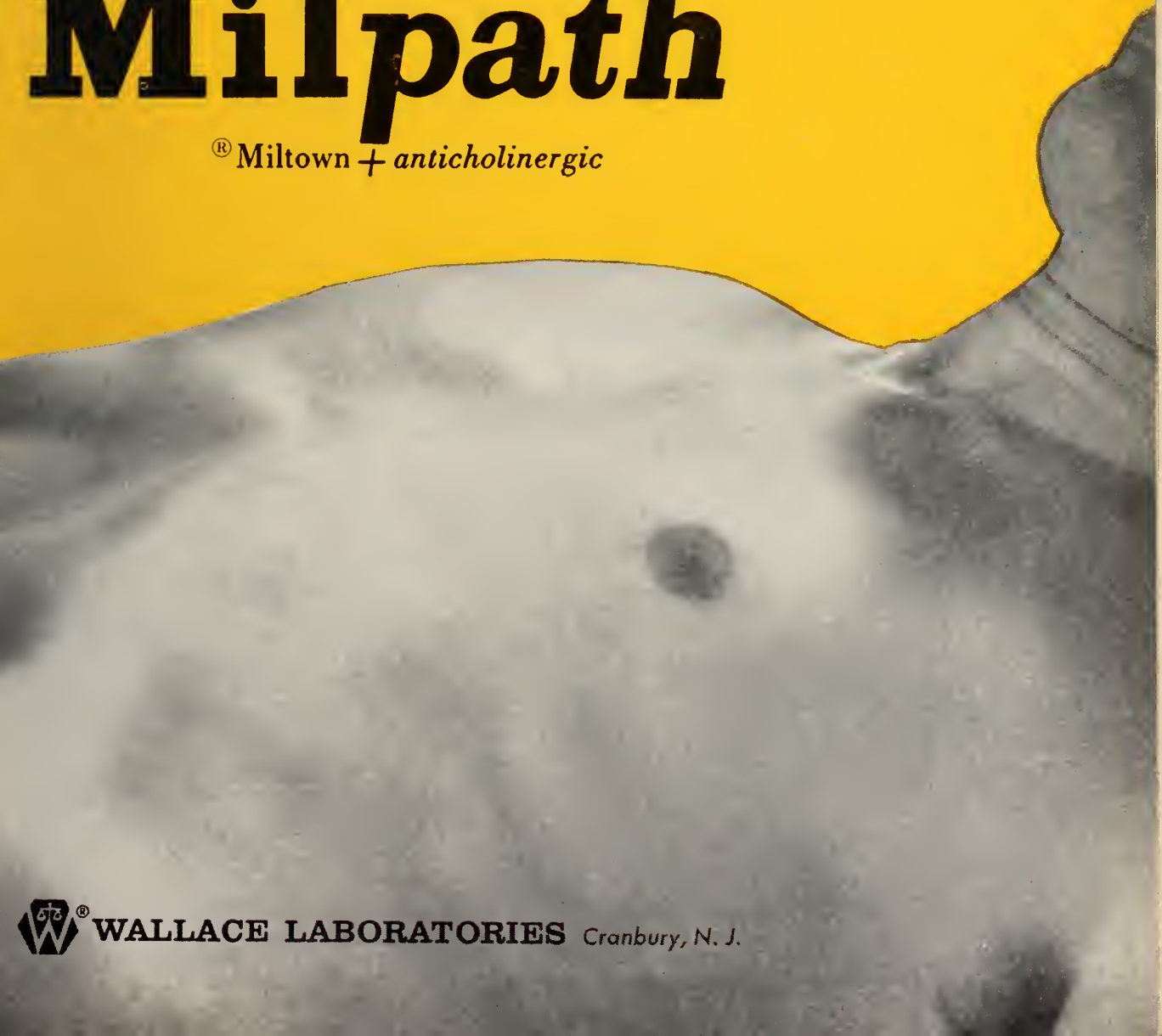
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leave his young wife with her parents. He boarded with two other students, who all lived a meager life, — "milk we could not afford, cheese none, but very little butter." They bought their own grain and baked their own bread. He still suffered from headaches and many digestive upsets, very likely caused mainly by malnutrition. In August, 1823, he was arrested for body snatching, commited the year before, trying to earn some money for his tuition.

Before entering Dartmouth College, Knowlton had worked with several physicians, especially with Dr. Amos Twitchell in Keene, New Hampshire. Knowlton usually walked from Keene to Hanover and back, a distance of nearly 70 miles. He received his doctor degree in 1824, after having served two months in jail on account of his resurrection affair, his father paying the fine of $284.26.

### Starts Practice

He started practicing first in Hawley, near Greenfield, and moved later to North Adams in 1827, and settled finally in Ashfield, Franklin County, located in the northwestern part of Massachusetts.

Knowlton was an agnostic, infuriating the townspeople by playing the violin at home during church time on Sunday mornings. In the obituary notice published in the *Boston Medical and Surgical Journal* (XLV, 6, Sept. 10, 1851) it says, "As a man he was 'odd,' as a citizen he was upright, as to his religious sentiments we pass them in silence."

The "Fruits of Philosophy" was not Knowlton's first book. In 1829, he published "Elements of Modern Materialism: Inculcating the ideas of a future state, in which all will be more happy, under whatever circumstances they may be placed than if they experienced no misery in this life."

### Peddled His Own Books

Knowlton had moved his family to North Adams in 1827 to be near a printing press. One thousand copies were printed of the "Elements of Modern Materialism," at a cost of 90 cents each. He peddled his own book in Massachusetts and western New York, and was arrested in Amherst for not having a license. Knowlton assumes that this was done at the request of President Humphrey of Williams College because Knowlton was an infidel, a deist, and a bad character. Knowlton rejected all spiritual concepts as soul and conscience; words as "good" and "evil" meant nothing to him, except as they resulted in human happiness and unhappiness. His free-thinking attitude played quite a role in the attempt to suppress the "Fruits of Philosophy" which legally was classified as obscene, but the verdict was more against the man than the book. At Taunton, Knowlton was fined 50 dollars and costs ($27.50) for publishing his book. His prison sentence in Cambridge was instigated by the complaint of a colleague, a physician located in Lowell.

Knowlton's interest in sexology was of a personal nature. He was worried deeply as a young man about "Gonorrhea dormientum," a more polite word for self abuse, and published a paper on this, where he states, "There I saw, and there I lay, brooding over my sad case, day after day."[6] Knowlton was unduly impressed by Tissot's still-widespread-assumption that "the loss of one ounce of semen is equal to the loss of 40 ounces of blood."

### "Without Sacrifice of Enjoyment"

Only 10 of the 110 pages of the "Fruits of Philosophy" deal with "Of Preventing Conception Without Sacrifice of Enjoyment." All the other pages give information on generation, the signs of pregnancy and remarks on the reproduction instinct, and a long argumentation on the morality of his anti-conception art. The "Fruits of Philosophy" has no illustrations or diagrams, so the author takes great pains to define all the anatomical terms used.

In Knowlton's day little was known regarding ovulation, menstruation and fertilization. It was in 1875, that Oscar Hertwig, Professor of Anatomy and Embryology at Jena, Germany, discovered that fertilization consists in the penetration of the egg by the sperm. Knowlton was sure that those "seminal animalcules which avoid the light and delight in the shade" were essential for impregnation. This, then, became the rationale for his anti-conception art. "My method operates in a two-fold manner, either of which might perhaps be effectual. It consists of syringing the vagina, soon after the male emission into it, with some liquid, which will not merely dislodge nearly all the semen, as simple water would do — the female being in the most proper position for the operation — but which will destroy the fecundating property of any portion of semen that may remain."

Knowlton's argumentation was based on physiological reasons, not on moral, or ethical reasons. His chief method was douching, as the rubber pessary came into being only in the 1840's. The solutions he recommended were quite specifically:

"1. Of Alum, to a pint of water, a lump as large as a large chestnut.

"2. Of Sulphate of Zinc, to a pint of water, a large thimble full.

"3. Of Sal Eratus, to a pint of water, two common sized even teaspoons full.

"4. Of good Vinegar, to a pint of water, four or five greatspoons full.

"5. Liquid Chloride of Soda, to a pint of water, four or five greatspoons full."

### "A Minute's Time and No Light"

Always aware of the poor people, he stated, "I am quite confident that a liberal use of pretty cold water would be a never-failing preventative"; also that this method is "very simple and very easy, requiring but a minute's time and no light, if the liquid be at hand." This reminds one of Abraham Stone's string of 28 dif-

*(Continued on Page 294)*

*new dimension in menstrual hygiene*

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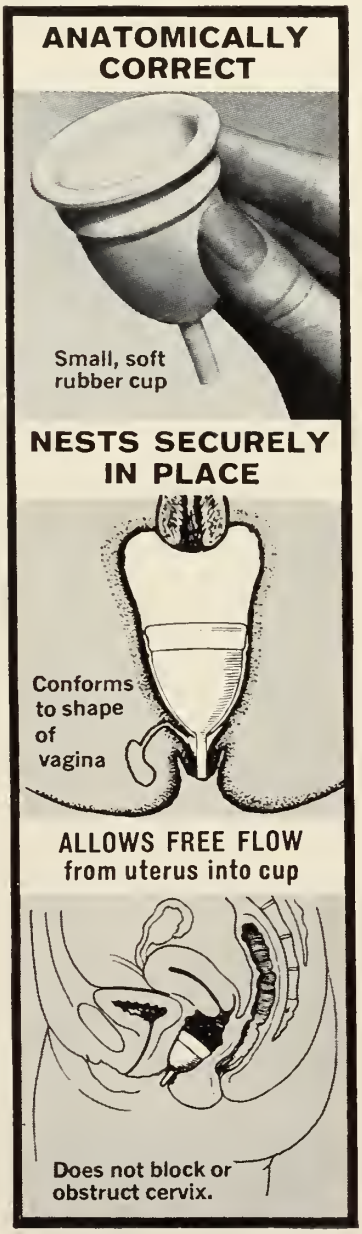
*Tassette* actually improves vaginal flora, inhibiting growth of pathogenic organisms. Bacteriological studies show: significant *decrease* in long Gram negative bacilli, and fungi—mostly Candida (Monilia) albicans; and *increase* in Gram positive short rods and cocci.

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*Please write for literature.*

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ferent colored beads, used in India, to determine the safe period for those who do not have a calendar.

How original Knowlton was regarding his anti-conception art is an open question. Douching was very likely practiced before, but he advocated and endorsed this method as a scientific and safe one, and he put it into public print. This is not always a wise thing to do as others, including myself, found out in similar experiences, both in Germany and in the United States.

We know little about the immediate reaction, by the profession or the public, as Knowlton's autobiography ends in 1829. The "Fruits" were practically not commented on in the professional literature, with the exception of the *Boston Medical Journal*, which concluded "The less that is known by the public at large the better it will be for the morale of the community."[7]

Knowlton was not a fanatic regarding anti-conception. He was more interested in the betterment of the minds of man. On the day of his release from prison, he gave two lectures which have been published as: "Two Remarkable Lectures — Delivered in Boston, by Dr. C. Knowlton, on the day of his leaving the jail at East Cambridge, March 31, 1833, where he had been imprisoned, For Publishing a Book. Boston: Publised by A. Kneeland, Proprietor, at the office of the Investigator, Lower Julien Hall, Corner of Congress and Milk Streets, 1833."

Knowlton does not mention anything regarding "birth control" in these lectures but developed an interesting pre-Darwin theory of the physical evolution of man as a result of a long series of natural operations — and by improvement upon the orang-outang, or some other animal, may in a few thousands or millions of years be completed.

Knowlton agitated the cause of free speech, organized "The Friends of Mental Liberty" after his imprisonment, but he also soon became a well-to-do physician, a thoroughly respected member of the community, raised a family of five children, published regularly in the *Boston Medical Journal*, limiting himself strictly to clinical papers. He died of angina pectoris on February 20, 1850, when 50 years old.

### A Victorian Cause Célèbre

It was in England that the "Fruits of Philosophy" became famous and notorious long after the death of its author. They had been first reprinted in 1834. Up to 1876, approximately 42,000 copies were sold. In 1877, the "Fruits" became a cause célèbre of the Victorian age. Henry Cook of Bristol, it has been alleged, interleaved obscene pictures with the Knowlton pamphlet and was sentenced to two years of imprisonment at hard labor.[8] I am sorry to say that I have not yet ascertained what kind of obscene pictures they were. I assume they were diagrammatic illustrations of the female and male reproductive organs.

Mrs. Basant and her co-worker, Charles Bradlaugh, then stepped in and made "The Fruits" a test-case. They organized the *Free Thought Publishing Company* for the express purpose of reprinting and publishing the "Fruits." The London police were duly notified and both were promptly arrested and tried before the Lord Chief Justice, but Mrs. Basant won the case, arguing the merit of getting contraceptive information to the poor. An enormous increase of the sale of the "Fruits" took place, nearly 185,000 copies were sold at sixpence in three and one-half years. French and Dutch translations also appeared. Norman F. Himes has linked the declining birth rate in England with the wide distribution of Knowlton's pamphlet. This, surely, is an overestimate of its effect but, nevertheless, Knowlton has good claim as the American pioneer in the birth control movement.

*(To Be Continued in April Issue)*

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## How Ohio Counties Were Named

(See also *The Journal*, p. 1486, November 1960; p. 144, February; p. 768, July; p. 878, August; p. 1240, November, 1961; and p. 38, January 1962.)

*Trumbull* (1800): In honor of Jonathan Trumbull, who was a prominent Connecticut governor.

*Tuscarawas* (1808): An Indian word meaning "open mouth"; in this case, referring to the river of the same name.

*Union* (1820): So named because it incorporated parts of four counties.

*Van Wert* (1837): Named for Isaac Van Wert, another one of Major's Andre's captors.

*Vinton* (1850): In honor of S. F. Vinton, a prominent Whig.

*Warren* (1803): In memory of Gen. Joseph Warren, who was killed at Bunker Hill.

*Washington* (1788): Named for Gen. George Washington, who was then president of the Constitutional Convention.

*Wayne* (1812): For General Anthony Wayne, who made Ohio safe for settlement.

*Williams* (1824): Named for David Williams, one of Major Andre's captors.

*Wood* (1820): Named for builder of Fort Meigs, Captain Wood.

*Wyandot* (1845): Named for the Wyandot tribe which lived there.

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# An Enhancement Test for the Detection Of Rheumatoid Serum

FRANCIS W. McCOY, M.D., and MELVIN S. RHEINS, Ph.D.

OF THE various direct laboratory procedures employed for detecting and measuring the so-called rheumatoid factor often present in the serum of patients ill with rheumatoid arthritis, the sensitized sheep cell agglutination tests[1,10,14] and the FII modification[6] and the latex-fixation tests, as introduced by Singer and Plotz,[11] seem to correlate most satisfactorily with the positively diagnosed disease.

However, since serum from certain rheumatoid patients fails to react consistently or not at all, in these tests, modifications of these procedures, possessing greater sensitivity, have been reported. Among the better known modifications is the sensitized sheep cell inhibition test as devised by Ziff et al.[15] A similar test employing latex-fixation has been described by Hall and his associates.[5]

Based on the assumption that an insufficient quantity of rheumatoid factor is responsible for the incapacity of some rheumatoid sera to react directly in serologic tests, the conventional latex-fixation test was altered so as to include addition to the test system of an aliquot of rheumatoid serum containing a previously measured amount of this factor. Thus, it has been possible to increase the sensitivity of the conventional or direct latex-fixation test. This modification is referred to as the "enhancement test."

An evaluation of this procedure is the principal subject of this paper. An inhibition test, the technique of which is in keeping with the general methods employed in these laboratories, was also investigated and will be discussed.

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## Materials and Methods

*Latex-Fixation Test.* The standard procedure as routinely employed in these laboratories is a "drop" modification[8] of the test described by Singer and Plotz.[11] It consists of mixing 2 drops (from a dropper pipette) of a 1:20 dilution of the test serum (prepared with physiologic — borate buffer) and 2 drops of a suspension of polystyrene latex particles (1.17 micra, average diameter) previously sensitized with polio-immune globulin, (250 gamma of globulin per ml. of antigen) in small test tubes (12 x 75 mm). After incubation at 56° C (water bath) for 30 minutes, the tubes are centrifuged lightly and examined by trans-illumination for evidence of flocculation. The intensity of the reaction may be graded from 4 plus to minus. If desired serum rheumatoid factor may be

titrated by the usual serial doubling dilution method. Rarely is it necessary to extend the serum dilutions beyond 1:5120.

### Enhancement Test

To ½ flocculating unit of rheumatoid factor (previously determined and contained in 2 drops of the serum dilution) add 4 drops of latex antigen prepared so that one ml. of antigen has a gamma globulin concentration of 125 gamma per ml. of antigen. Mix by shaking and incubate at 56° C (water bath) for 15 minutes.

Introduce 2 drops of a 1:5, or more, dilution of test serum; mix and incubate an additional 15 minutes at 56° C. After light centrifugation in an angle centrifuge the tests are read by transillumination. The intensity of reaction is graded from 4 plus to minus.

An antigen control containing the ½ flocculating unit and a serum control are included with each battery of tests, as are known false negative serum and known negative (normal) serum controls.

### Inhibition Test

Because of the necessity for performing a multiplicity of procedures with a given blood sample, it has been advantageous to employ microtechniques wherever possible, as indicated in the foregoing. In keeping with this point of view, the latex-fixation inhibition test described by Hall et al.[5] and patterned after the red cell inhibition test of Ziff and his colleagues[15] was modified slightly and converted to a micro- or "drop" basis.

Two drops of the serially diluted test serum (1:5 through 1:20) are mixed with 2 drops of rheumatoid serum, previously diluted so as to contain 8 flocculating units in this volume, and 4 drops of latex antigen containing 250 gamma of polio-immune globulin per ml. of antigen. After 30 minutes' incubation at 56° C (water bath) followed by light centrifugation, each of the three dilutions of the test serum is examined for inhibition of flocculation by comparison with the control which contains 8 flocculating units of rheumatoid factor and borate buffer substituted for the test serum dilution.

A small number of representative sera were examined for inhibitor by this test. Sera from rheumatoid patients which were reactive in the conventional latex-fixation test rarely were found to possess inhibiting properties. Generally, those sera designated as false negative demonstrated inhibitor, but the extent of the inhibition was less than that observed with normal serum and apparently is inversely related to the concentration of rheumatoid factor in the test serum.

### Reactivity of Serum Fractions

Sera were fractionated by the dialysis method of Ziff et al.[15] and by the $Na_2SO_4$ procedure of Thurston and his associates.[13] Untreated aliquots of each serum sample, as well as the recovered globulins, were tested by the conventional latex-fixation test (single dilution, 1:5), the enhancement test (1:5 dilution), and by the inhibition test (serum dilutions of 1:5, 1:10).

A comparison of these results suggested that the globulins recovered by the $Na_2SO_4$ method possibly were more reactive than were those obtained by the dialysis method, as measured by the conventional and enhancement tests. Neither technique revealed any marked superiority over the use of untreated serum in demonstrating inhibitor, and, in fact often resulted in some loss of this property.

### The Effect of Prior Heating of Sera And Serologic Testing

Brine, Wedgwood and Clark[3] have reported the effectiveness of prior heat-inactivation of test sera on reducing or eliminating prozone phenomena sometimes observed when performing the latex-fixation test.

Several sera were heated at 56° C for 30 minutes and subsequently tested by the conventional latex-fixation, enhancement and inhibition techniques. These results were compared with those obtained by the simultaneous testing of unheated counterparts of the same serum samples. The most marked effect of the heat treatment appeared to be the virtual elimination of inhibitor in the normal sera. These sera, it should be recalled, are those in which inhibitor is most often demonstrated. Heating had little or no effect on either of the other tests or serum samples.

### The Use of Heated "Antigen" Globulin On the Testing Procedures

In keeping with the recommendation of Franklin et al.,[4] the polio-immune globulin was heated at 63° C for 10 minutes before being diluted appropriately and mixed with a suspension of latex particles for sensitization. Similar antigens for the various tests were prepared in the usual manner. Sera were tested with both groups of antigens.

SERA — The sera for this study were obtained from the Arthritis Clinic of the University Hospital, Columbus, Ohio, and from the Laboratories of the Ohio State Department of Health. (The clinical state of the patients from whom these sera were procured will be discussed in the text).

### Experimental Results

*Results of Testing Sera by the Conventional, Enhancement and Inhibition Techniques.* Three hundred serum samples, divided as follows, were examined serologically before and after $NA_2SO_4$ precipitation. One hundred sera were from arthritis patients and consistently reacted in the conventional latex-fixation test. One hundred other sera were from patients ill with arthritis, but which presented no evidence of rheumatoid factor when examined by the conventional test. The third group of one hundred sera was designated as normal.

The results of those tests are recorded in Table 1. The marked gain in the incidence of reactivity is most

striking in the false negative group of sera when examined by the enhancement test. Although 23 per cent of the globulins from these sera gave positive demonstrations by the conventional technique, this number was approximately doubled when tested by the enhancement technique and untreated sera, and tripled (69 per cent) when the globulins were employed. All sera reactive by the conventional procedure, also proved reactive in the enhancement test, whether whole sera or globulins were examined. Three of the globulins from the normal sera were positive the 1:10 serum dilutions and the globulin dilution paralleled the data obtained with normal sera.

*Examination of Serial Sera from an Arthritis Patient.* It is generally conceded that serologic titer of the rheumatoid factor does not necessarily parallel the course of the patient's disease. Equally true, however, is the observation that the majority of sera from patients with active disease will demonstrate this factor. In the instance of the latex-fixation test, the incidence ranges from approximately 70 per cent to 85 per cent, depending on the study.[5, 8, 12]

TABLE 1. *Comparison of Enhancement, Conventional, and Inhibition Tests with 100 Rheumatoid Arthritis False Negative and Normal Sera and the Effect of $NA_2SO_4$ Precipitation.*

| DESCRIPTION OF TEST SERA | NUMBER OF SERA TESTED | CONVENTIONAL (Serum diluted 1:5) | | ENHANCEMENT (Serum diluted 1:5) | | INHIBITION | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Positive before Treatment | Positive after $Na_2SO_4$ Precipitation | Positive before Treatment | Positive after $Na_2SO_4$ Precipitation | Number positive before treatment | | Number positive after $Na_2SO_4$ precip. | |
| | | | | | | 1:5 | 1:10 | 1:5 | 1:10 |
| Rheumatoid Arthritis | 100 | 100 | 100 | 100 | 100 | 11 | 4 | 4 | 2 |
| False Negative | 100 | 0 | 23 | 45 | 69 | 93 | 75 | 63 | 18 |
| Normal | 100 | 0 | 3 | 1 | 6 | 99 | 88 | 88 | 44 |

with the conventional method, while this was increased to six (6 per cent) with the enhancement test.

Based on previous experience, the results of the inhibition tests were predictive. The highest incidence of inhibitor was found among the normal sera, 99 per cent of which demonstrated inhibition in the 1:5 dilution of serum and 88 per cent in the 1:10 dilution. After precipitation, the number of globulin samples presenting positive reactions was reduced to 88 per cent and 44 per cent respectively. The same trend was observed with the results of similar tests conducted with the false negative and known positive samples, although the absolute incidence of inhibiting substances differed. The number of false negative sera exhibiting inhibitor in the 1:5 dilutions of the initial serum samples (93 per cent) approached the 99 per cent incidence assigned to normal sera, while the 11 per cent of known positive sera represented a marked reduction in incidence. The results seen with

Of particular interest has been the group of arthritic patients whose sera are nonreactive by the conventional latex-fixation test. Since the enhancement test, as described previously, provided a method of increasing the sensitivity of this test, it seemed valuable to determine the efficacy of this test for examining serially procured sera from a single patient of the aforementioned group.

A patient regularly seen in the arthritis clinic and who presents symptoms of classical rheumatoid arthritis was selected for study. Six serum samples from this patient, collected during a 15 month period, had been examined by conventional latex-fixation tests and consistently failed to demonstrate rheumatoid factor. The globulins from these sera and the untreated whole serum samples were then tested by the three techniques, as before.

As may be seen in Table 2, the globulins behaved as did the whole sera in their failure to react in the

TABLE 2. *The Results of Testing Serially Procured Sera from an Arthritis Patient Who Is Unreactive by Conventional Latex-Fixation Tests.*

| SERUM NUMBER (CONSECUTIVE SAMPLES) | CONVENTIONAL (Serum Diluted 1:5) | | ENHANCEMENT (Serum Diluted 1:5) | | INHIBITION | | | |
|---|---|---|---|---|---|---|---|---|
| | Untreated Serum | After $Na_2SO_4$ Precipitation | Untreated Serum | After $Na_2SO_4$ Precipitation | Untreated Serum | | After $Na_2SO_4$ Precip. | |
| | | | | | 1:5 | 1:10 | 1:5 | 1:10 |
| 1 | — | — | + | 3+ | 3+ | + | 2+ | — |
| 2 | — | — | + | + | 4+ | 3+ | + | — |
| 3 | — | — | 2+ | 3+ | 2+ | + | + | — |
| 4 | — | — | + | 2+ | 2+ | 2+ | + | — |
| 5 | — | — | 3+ | 2+ | 4+ | 3+ | — | — |
| 6 | — | — | + | 2+ | 4+ | 2+ | + | + |

TABLE 3. *Comparison of Serologic Tests on Sera from Ten Arthritic Patients Usually Negative by the Conventional Latex-Fixation Test.*

| PATIENT | NUMBER OF SERA TESTED FROM EACH PATIENT | CONVENTIONAL (Sera diluted 1:5) | | ENHANCEMENT (Sera diluted 1:5) | | INHIBITION | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Positive Untreated Sera | Positive after $Na_2SO_4$ Precipitation | Positive Untreated Sera | Positive after $Na_2SO_4$ Precipitation | Positive Untreated Sera Dilution of Serum 1:5 | 1:10 | Positive after $Na_2SO_4$ Precipitation Dilution of Serum 1:5 | 1:10 |
| 1 | 3 | 0 | 0 | 1 | 1 | 3 | 1 | 3 | 1 |
| 2 | 3 | 1 | 1 | 2 | 3 | 2 | 1 | 1 | 0 |
| 3 | 6 | 0 | 0 | 6 | 6 | 6 | 6 | 5 | 1 |
| 4 | 3 | 0 | 0 | 0 | 0 | 3 | 3 | 3 | 1 |
| 5 | 4 | 0 | 0 | 0 | 2 | 3 | 3 | 4 | 1 |
| 6 | 5 | 1 | 4 | 5 | 5 | 4 | 4 | 0 | 0 |
| 7 | 4 | 0 | 1 | 0 | 1 | 4 | 4 | 3 | 1 |
| 8 | 6 | 0 | 1 | 4 | 6 | 6 | 6 | 4 | 1 |
| 9 | 3 | 0 | 1 | 2 | 2 | 2 | 2 | 2 | 0 |
| 10 | 3 | 1 | 1 | 2 | 3 | 3 | 2 | 2 | 0 |

conventional test. Both sets of samples, however, presented positive demonstrations by the enhancement technique; the globulins, perhaps somewhat stronger. As noted previously, the whole sera contained inhibitors in both the dilutions tested (1:10, 1:5). The recovered globulins were markedly less inhibitory, and in most instances the inhibitor appeared in minimal concentrations.

Multiple serum samples from 10 other patients, clinically similar to the patient previously described, were tested in a like manner. These sera like the others had been collected over approximately a 15 month period. On infrequent occasions, a single serum sample from these patients reacted weakly in the conventional test, as shown in Table 3. From the same table, the advantage of the enhancement test, particularly when performed with the serum globulins, is quite apparent. Of a total of 40 samples tested, 29 reacted positively with this method. In every instance but one, it was possible to evoke a reaction with one or more of the test globulins. Further comparisons with this test may be made readily from the recorded data. Again, the incidence and the extent of inhibition noted with the globulins were reduced when compared with the results observed with the sera.

*The Testing of Non-Rheumatoid Sera.* For purposes of further evaluating the testing procedures, sera were obtained from patients ill with a variety of diseases other than rheumatoid arthritis. In all, 66 sera were examined. With the exception of syphilis, none of the sera were from patients ill from diseases of microbial etiology. Of the remaining 55 sera, 13 were from patients with other collagen disorders (9 lupus erythematosus, 4 scleroderma). The majority of the other sera were from patients presenting diagnoses of malignancy. The results of testing these serum samples are recorded in the summary Table 4.

Only one of these specimens (from a lupus erythematosus patient) reacted positively in the conventional test, and then only upon testing of the globulins. Ten of the 66 whole sera were positive by the enhancement test; (4 of which were from patients suffering from lupus erythematosus and 2 from patients with scleroderma). This number was increased to 17 upon testing of the globulins. It is interesting that 7 of the 17 positive reactions occurred with globulins from sera from patients with collagen disorders (lupus erythematosus, scleroderma). This represents a disproportionate incidence of reactivity when compared with the results obtained with the other samples. The tests for inhibitors in the sera and globulins followed the pattern of reactivity generally observed in these laboratories.

*Table for Comparison of Results.* For purposes of comparison, a summary table (Table 4) has been prepared. Perusal of these data would seem to endorse the enhancement test, especially when performed with recovered globulins, as the test of choice for demonstrating the so-called rheumatoid factor.

## Discussion

Any discussion of the experimental results just described should be carefully prefaced by a statement of the prime purpose of this study. In a previous report from these laboratories,[8] 86 per cent of the sera from 120 patients considered to be ill from rheumatoid arthritis reacted positively in the latex-fixation test. This figure is similar to that of Hall and his associates[5] who demonstrated reactivity in the sera from 82 per cent of 177 patients by direct latex-fixation tests (i. e. by testing sera or euglobulins). It was because of concern for the remaining 14 to 18 per cent of rheumatoid patients that this study was initiated. In analyzing the data presented in Tables 1 and 4, it should be noted that the 100 sera designated as "false negative" normally do not comprise 50 per cent of rheumatoid sera serologically, as might be inferred from the tables, but actually represent the 14 to 18 per cent of rheumatoid patients as indicated above. Thus, by obtaining a direct serologic demonstration with 69 per cent of these sera, the final figure for serologic reactivity of all clinical rheumatoid patients is approximately 95 per cent, providing that the enhancement test as performed with globulins is employed.

As a routine procedure in these laboratories, all test

sera are precipitated by the $Na_2SO_4$ method, and the recovered globulins diluted 1:5 and examined by the enhancement test. By a single tube test then, exclusive of proper positive and negative controls, the rheumatoid factor can be demonstrated in the sera from a large percentage of patients.

From the experiences related here, less reliance is placed on the latex-fixation inhibition test. In addition to being an indirect test, which seems less desirable than a direct demonstration of the serum entity in question, the results obtained by this technique may be influenced by the treatment rendered the test substance, i. e. heat or chemical precipitation. Generally, however, experience with this test is in agreement with that described by Hall et al.[5]; sera from classical rheumatoid patients usually fail to inhibit the latex-fixation by a known positive serum; sera from patients with other connective tissue diseases occupy a more median position, and sera from normal individuals most often demonstrate evidence of inhibitor.

The incidence of reactions noted with the serum samples (and resultant globulin fractions) from patients ill with diseases other than clinically diagnosed arthritis is of interest. It is somewhat understandable that a percentage of sera from lupus erythematosus and scleroderma patients may present positive demonstrations by these testing procedures, since, as Bloch[2] has pointed out, rheumatoid arthritis and the other collagen diseases often are closely related clinically and pathologically. However, the 25 per cent (9 of 36 samples) of globulins from patients with a diagnosis of malignant tumor is not as explainable. Other workers have commented on demonstrating positive reactions with sera from other than arthritis patients. Kunkel et al.,[7] for example, reported that the sera from 6 of 61 patients with sarcoidosis were positive by the latex-fixation technique.

By way of speculation, the general statement could be made that as more sensitive modifications of a given serologic procedure are introduced, the greater are the chances of observing reactivity in test samples procured from disease states other than the one in question. This has been true in noting positive reactions to serologic tests among lepers. This does not necessarily imply a loss of specificity, but rather an ubiquity of the substance being measured. With the less precise (less sensitive) technique, only the sera from patients containing larger quantities of the factor (or antibody) will reach positively. Should this serum factor frequently be associated with a particular disease entity, then it follows that a percentage of these patients will present positive tests. As efforts are made to increase the sensitivity of the testing procedure, i. e. to demonstrate smaller amounts of the serum factor, it is possible to demonstrate the same factor (or similar ones) in the sera from patients with closely related or, perhaps, apparently distinct diseases.

The nature of the factor, or substance, being measured obviously becomes important. If, as in the case of rheumatoid arthritis, the suggestion has been made that the rheumatoid factor is autoantibody, it becomes necessary to identify the antigen. Since it is possible to employ the patient's own gamma globulin as antigen, and also as the source of rheumatoid factor,[12] one would assume that the antigen is gamma globulin. However, positive reactions also can be obtained with globulin antigens from other species.[9]

The problem of identifying the rheumatoid factor, if in fact it is a single entity, is further complicated by the variety of testing procedures now employed. Discrepancies among the techniques in parallel tests commonly are encountered. These may represent differences that might be anticipated as the results of procedures involving a variety of mechanics. However, it is also possible that more than one serum factor is being measured, and that the serologic test antigens are actually mixtures, permitting the demonstration of mixed systems. By manipulation of antigen, as with heating, or of serum, by heating of fractionation, certain systems may be favored for demonstration. These need not be the same for all serum samples, even from the same disease state.

The foregoing comments should not be construed as derogatory to the presently employed procedures, among them the "enhancement test" just described, but rather to point out the need for careful evaluation of techniques in terms of what they measure. Thus, the necessity for absolute identification of the

TABLE 4. *Summary Table.*

| Test Sera | Number of Samples | Conventional L. F. (Serum diluted 1:5) | | Serologic Test (No. Positive) Enhancement L. F. (Serum diluted 1:5) | | Inhibition L. F. | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Untreated | Globulins | Untreated | Globulins | Untreated 1:5 | Untreated 1:10 | Globulins 1:5 | Globulins 1:10 |
| RHEUMATOID ARTHRITIS | 100 | 100 | 100 | 100 | 100 | 11 | 4 | 4 | 2 |
| FALSE NEGATIVE (Rheumatoid Arthritis) | 100 | 0 | 23 | 45 | 69 | 93 | 75 | 63 | 18 |
| NORMAL | 100 | 0 | 3 | 1 | 6 | 99 | 88 | 88 | 44 |
| OTHER COLLAGEN DISEASES (L. E., Scleroderma) | 13 | 0 | 1 | 6 | 7 | 13 | 11 | 11 | 5 |
| MULTIPLE MYELOMA | 5 | 0 | 0 | 0 | 1 | 5 | 5 | 5 | 3 |
| SYPHILIS | 11 | 0 | 0 | 0 | 0 | 11 | 8 | 11 | 7 |
| HODGKIN'S DISEASE | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 |
| MALIGNANCIES* | 36 | 0 | 0 | 4 | 9 | 36 | 30 | 33 | 26 |

*Include Carcinomas, Sarcomas, Leukemias

rheumatoid factor then is obvious, and then re-interpretation of the test procedures will be necessary.

## Summary

1. By means of the "enhancement" latex-fixation test, it has been possible to detect rheumatoid factor in 45 per cent of rheumatoid patients considered serofalse negative by the more conventional procedure.

2. By testing the globulins from these patients, the incidence of positive reactions increased to 69 per cent.

3. Associated with this apparently sensitive test, there was noted an increase in positive reactions with sera from patients with malignant tumors and other collagen diseases.

4. The suggestion is made that the isolation of the rheumatoid factor(s) will be necessary for exact evaluation of the serologic test now employed.

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UNTREATED HYPERTENSION.— In this review of untreated hypertension emphasis has been placed on the following features of this disease:

Primary or essential hypertension is a disease which begins almost exclusively during youth and early middle age.

After the hypertensive state is established, the victim survives an average period of 20 years, during the first two thirds of which time he is asymptomatic.

A course of benign and uncomplicated nature for 10 years implies a favorable prognosis, whereas progressive increase in pressure during a short period is likely to initiate a malignant or accelerated form of the disease which if not interrupted by effective treatment, will kill in haste.

Death in malignant or accelerated hypertension commonly is an expression of arteriolar damage leading to or attended by renal insufficiency progressing to the uremic state.

Death in essential hypertension results from atherosclerotic disease. Evidence, clinical, pathologic, and experimentally derived, indicates acceleration of atherosclerotic disease by hypertension. The two processes, hypertension and atherosclerosis, would appear each to aggravate the other, but to arise from independent predispositions or sources.

Therapeutic measures which reduce blood pressure unquestionably influence favorably the prognosis in malignant or accelerated hypertension where arteriolar lesions are the common and direct cause of death; the influence of therapy on the survival of patients with benign hypertension is not established, death resulting commonly from the effects of atherosclerotic lesions related only in secondary fashion to the high blood pressure. — Raymond D. Pruitt, M. D., Houston, Texas: Untreated Hypertension. *Southern Medical Journal*, 54:378-387, April, 1961.

# Evaluation of Deladumone®

## The Control of Postpartum Breast Engorgement, Lactation and Pain.

BASIL V. BISCA, M.D., NICHOLAS J. TETERIS, M.D.,
and MICHAEL E. YANNONE, M.D.

MORE and more it is becoming less and less fashionable to breast feed. Many "modern" mothers, because of either personal preference, medical contraindications or numerous environmental pressures, have turned to bottle feeding as a more desirable method of infant nutrition. The arguments pro and con are all too numerous, controversial and familiar to warrant discussion at this time.

The search for means to adequately control and suppress postpartum breast engorgement and its attendant symptoms has led to the investigation of numerous sex hormones and their combinations.[3,4,7-9,11] A knowledge of the physiologic processes responsible for lactation is necessary to better understand the rationale behind any therapeutic regime.[14] Estrogen and progesterone stimulate the development of breast tissue causing secretion and excretion of milk. Prior to the onset of labor, the level of estrogen and progesterone drops precipitously and their inhibitory effect on the pituitary gland is removed. Parturition serves as the stimulus to activate the pituitary gland to produce and release prolactin and oxytocin. Prolactin stimulates alveolar milk secretion, and oxytocin controls milk ejection. Removal of milk from the alveoli by the suckling infant is the means by which the process of lactation is continued.

It is obvious that any successful medication must: (1) overcome the stimulation of the alveolar system by the pituitary substances elaborated, and (2) produce no undesirable side effects, such as post-suppression rebound of breast engorgement and lactation, withdrawal bleeding, nausea and vomiting, and masculinization.[11]

### Methods and Materials

The patients were divided into three groups as follows: (A) those receiving preparation HV-45* and breast binder; (B) those receiving diethylstilbesterol and breast binder, and (C) those using only a breast binder. The only criterion utilized in the selection of patients for this study was an unwillingness to nurse for personal reasons. The group varied in age, parity and previous nursing experience. No attempt was made to equate the three study groups in this regard. No fluid restrictions were imposed. All patients were on regular diets. Patients under diuretic therapy were automatically excluded from this series. The postpartum routine was otherwise unaltered as regards analgesics, laxatives, sedatives and oxytocics.

A total of 70 patients received 1 cc. of preparation HV-45 intramuscularly within one hour following delivery. A breast binder was also applied. Of this number adequate follow-up was obtained in 53 patients (71 per cent). Patients in Group B received diethylstilbesterol 15 mg. in divided doses over five days, (5, 4, 3, 2, 1 mg.) as soon after delivery as oral medication could be tolerated. In most instances this was started within two hours following delivery. A breast binder was also applied in these patients. Patients in Group C were treated by use of breast binder alone. In all cases breast binders were applied within one hour following delivery.

To facilitate statistical comparison, since there were 53 patients in Group A with adequate follow-up, only

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Submitted June 21, 1961.

*At the time of this study this product, identified only as preparation HV-45, later became known as Deladumone® 2X. E. R. Squibb & Sons, manufacturers.

the first 53 patients in Groups B and C, in whom adequate follow-up was obtained are included in this study. In all patients therapy was initiated prior to any evidence of engorgement or lactation.

All patients were seen at least once a day throughout their hospital stay which averaged five days. Questionnaires were sent to all patients approximately two weeks following delivery. Moreover, all patients were seen at their regular six weeks' postpartum visit. The information thus obtained from all sources was correlated and is included in the follow-up data.

The criteria employed for the evaluation of patients was as follows: (1) the onset, degree and duration of breast engorgement; (2) the onset, degree and duration of lactation; (3) the onset, degree and duration of pain; (4) the occurrence of nausea and vomiting, and (5) the occurrence of abnormal bleeding. Since the major portion of the evaluation was conducted following the discharge of patients from the hospital, by means of questionnaires and direct questioning without benefit of personal physical examination, it was deemed proper to evaluate patients while still in the hospital by similar methods. The following classification was thereby employed.

With regard to onset of symptoms, *immediate* means occurrence while still in the hospital, while *delayed* means occurrence following discharge from hospital. With regard to duration, degree and severity of lactation, engorgement and pain, *severe* means lactation, discomfort, tenderness and engorgement of more than 24 hours duration which required ice packs and codeine; *moderate* means lactation discomfort and some engorgement lasting not more than 24 hours; and *mild* means minimal leaking, fullness and no further therapy required.

## Results

*Onset of Symptoms.* Table 1 summarizes the findings in each group as to time of onset of symptoms. It is noted that for all three groups most of the symptoms occurred while the patients were still in the hospital. Moreover, there were fewer patients in Group A (those receiving preparation HV-45) who manifested delayed onset of breast symptoms.

*Severity of Lactation.* The number and percentages of patients experiencing lactation is presented in Table 2. The highest percentage of patients showing mild or absent immediate lactation (88 per cent) was in the group receiving preparation HV-45. Patients receiving diethylstilbesterol had absent or mild lactation in 76 per cent and those managed with breast binder alone had absent or mild lactation in 60 per cent.

*Severity of Engorgement.* The number and percentages of patients experiencing breast engorgement is presented in Table 3. The highest percentage of patients showing mild or absent immediate breast engorgement was seen in the group receiving preparation HV-45 (84 per cent). Patients receiving diethylstilbesterol had absent or mild breast engorgement in 78 per cent and those managed with breast binder alone had absent or mild breast engorgement in 66 per cent.

*Severity of Pain.* The number and percentages of patients experiencing pain is presented in Table 4. The highest percentage of patients showing mild or no immediate pain (90 per cent) was in the group receiving preparation HV-45. Patients receiving diethylstilbesterol had mild or no pain in 82 per cent and those on breast binder alone had mild or no pain in 58 per cent.

*Abnormal Bleeding.* Eight patients in Group A (15 per cent), 10 patients in Group B (19 per cent) and nine patients in Group C (17 per cent) manifested increased vaginal discharge and bleeding following discharge from the hospital. Since the patients in Group C received no medication, this occurrence was not considered significant. The information concerning this delayed bleeding was difficult to evaluate since it was obtained from the individual questionnaires and any change in the amount of lochia might be interpreted by the patient as abnormal.

*Nausea and Vomiting.* This was a very infrequent problem occurring in 0 per cent of patients in Group

TABLE 1. *Onset of Symptoms*

| Symptom | Group A | | Group B | | Group C | |
|---|---|---|---|---|---|---|
| | Immediate | Delayed | Immediate | Delayed | Immediate | Delayed |
| Lactation | 29 | 3 | 31 | 6 | 36 | 8 |
| Engorgement | 33 | 3 | 42 | 8 | 44 | 8 |
| Pain | 15 | 1 | 19 | 6 | 26 | 14 |
| Bleeding | 2 | 8 | 1 | 10 | 0 | 0 |
| Nausea/Vomit | 0 | 0 | 3 | 0 | 1 | 9 |

TABLE 2. *Severity of Lactation*

| Group | Severe | | Moderate | | Mild or Absent | |
|---|---|---|---|---|---|---|
| | Immediate | Delayed | Immediate | Delayed | Immediate | Delayed |
| A | 1 (2%) | 0 | 2 (4%) | 1 (2%) | 47 (88%) | 2 (4%) |
| B | 2 (4%) | 2 (4%) | 4 (8%) | 2 (4%) | 41 (76%) | 2 (4%) |
| C | 2 (4%) | 3 (6%) | 7 (14%) | 5 (10%) | 33 (60%) | 3 (6%) |

A, 6 per cent of patients in Group B and 2 per cent of patients in Group C. Patients in Group C received no medication.

## Discussion

A review of the literature clearly establishes that preparations containing combinations of hormones best meet the needs of both physician and patient in inhibiting postpartum breast engorgement, pain and lactation. Recent investigators agree that the combination of testosterone enanthate with estradiol valerate (Deladumone®) does satisfactorily control these symptoms. Stein[12] reported on the use of increasing dosages of Deladumone in a group of 339 patients. Best results were obtained in 136 patients who received 3.5 cc. of the drug. No significant untoward effects were seen from the use of 315 mg. of testosterone enanthate and 14 mg. of estradiol valerate. Watrous et al.[13] concluded that parenteral administration of 2 cc. of Deladumone was more effective than similar hormonal preparations administered orally. LoPresto and Caypinar[5] studied the effectiveness of Deladumone when given at different times during the course of labor and delivery. They found that when 3 cc. was given intramuscularly after the first stage of labor, 43 of 47 patients were asymptomatic while only 22 of 51 patients who received the drug in the immediate postpartum period were free of symptoms.

Blumen et al.[1] found that 2 cc. given immediately after the third stage of labor produced the best results. Rodenberg and Simon[10] concluded that 2 cc. of Deladumone administered immediately postpartum appeared to offer the best opportunity for providing adequate hormone dosage. Brown et al.[2] reported on the possible role of endocrine substances in the prevention of puerperal breast abscess. They concluded that the non-engorged, non-lactating breast offered less of an avenue for infection. Markin and Wolst[6] evaluated several hormone preparations and found that only Deladumone prevented the occurrence of delayed symptoms.

Our own experience supports the current conclusions on the effectiveness of Deladumone in the prevention of postpartum breast engorgement, pain and lactation. We found that 1 cc. of preparation HV-45 administered within one hour following delivery provided adequate suppression of symptoms.

TABLE 3. *Severity of Engorgement*

| Group | Severe | | Moderate | | Mild or Absent | |
|---|---|---|---|---|---|---|
| | Immediate | Delayed | Immediate | Delayed | Immediate | Delayed |
| A | 1 (2%) | 0 | 3 (6%) | 1 (2%) | 46 (84%) | 2 (4%) |
| B | 1 (2%) | 2 (4%) | 2 (4%) | 2 (4%) | 42 (78%) | 4 (8%) |
| C | 3 (6%) | 2 (4%) | 6 (12%) | 3 (6%) | 36 (66%) | 3 (6%) |

TABLE 4. *Severity of Pain*

| Group | Severe | | Moderate | | Mild or Absent | |
|---|---|---|---|---|---|---|
| | Immediate | Delayed | Immediate | Delayed | Immediate | Delayed |
| A | 1 (2%) | 1 (2%) | 3 (6%) | 0 | 48 (90%) | 0 |
| B | 1 (2%) | 2 (4%) | 2 (4%) | 2 (4%) | 44 (82%) | 2 (4%) |
| C | 2 (4%) | 1 (2%) | 5 (10%) | 3 (6%) | 32 (58%) | 10 (20%) |

## Summary and Conclusions

1. One hundred and fifty-nine patients were evaluated for the effectiveness of certain hospital regimens in controlling postpartum breast engorgement, lactation and pain.

2. Both endocrine preparations were effective in controlling the immediate symptoms. Control of the delayed symptoms, however, was best achieved by the use of preparation HV-45.

3. None of the regimens produced any significant changes in the lochia or withdrawal bleeding.

4. Side effects were not encountered in any significant degree. No nausea or vomiting was encountered in patients receiving preparation HV-45.

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# Toxic Hepatitis During Treatment with Methimazole (Tapazole®)

## Report of a Case with Apparent Recovery

JAMES I. TENNENBAUM, M.D., and O. HERMAN DRESKIN, M.D.

THE usual toxic reactions of therapy with methimazole (Tapazole®), an effective antithyroid drug, are well known. They occur in approximately 5 per cent of patients treated with the drug and include skin rash, fever and bone marrow depression.[1, 4, 5, 6] The present case is that of an unusual toxic reaction, hepatitis and jaundice, which has been reported previously on three occasions.[3] In each of these cases agranulocytosis was noted and the jaundice appeared three to five weeks after institution of therapy. A liver biopsy was performed in one case, and a postmortem examination of the liver was done in another.[1, 3] Because of the apparent rarity of liver toxicity due to methimazole, because this patient was also on therapy for only four weeks prior to the occurrence of jaundice, and because bone marrow depression was not present, the case is considered of general interest. A liver biopsy was performed in this patient.

### Case Report

A 38 year old colored married woman was admitted on May 31, 1960, with a one week history of itching about her arms and legs. She had complained of tiring easily, and of severe nervousness for several months prior to her admission. A basal metabolic rate in April was +54 per cent. Serum protein bound iodine was normal (4.3 micrograms per 100 ml.) as was cholesterol (215 milligrams per 100 ml). She was given Tapazole 20 mg. every eight hours as a therapeutic test and also to prepare her for thyroidectomy. She was also given phenobarbital 30 mg. four times a day on May 4, 1960. She took these drugs until admission.

One day prior to the onset of itching she noticed a papular rash on the neck and chest, and she noted dark urine and clay colored stools three days prior to admission. There was slight nausea but no vomiting or diarrhea. No abdominal pains were present but she did complain of a bloated feeling for three or four days. There was no history of food intolerance, but slight anorexia was present with a 6½ pound weight loss in two months. There was no history of contact with infectious hepatitis or of recent injections.

Family history, social history, allergic history and review of systems were noncontributory.

Physical examination revealed a well developed, well nourished, slightly ill colored woman who was in no distress. Blood pressure was 160/100, pulse rate 76 per minute, temperature 99.4°F., and respiratory rate 16 per minute. There was a generalized erythematous rash over the arms and thighs. Moderate scleral icterus was present. The thyroid was diffusely enlarged, the right lobe being much larger than the left. A bruit was present. The heart and lungs were normal. The liver was not palpable but there was slight punch tenderness over the lower right costal rib margin. No spleen or other abdominal masses were palpable. The rest of the physical examination was within normal limits.

Chest x-ray revealed a substernal thyroid to be the only

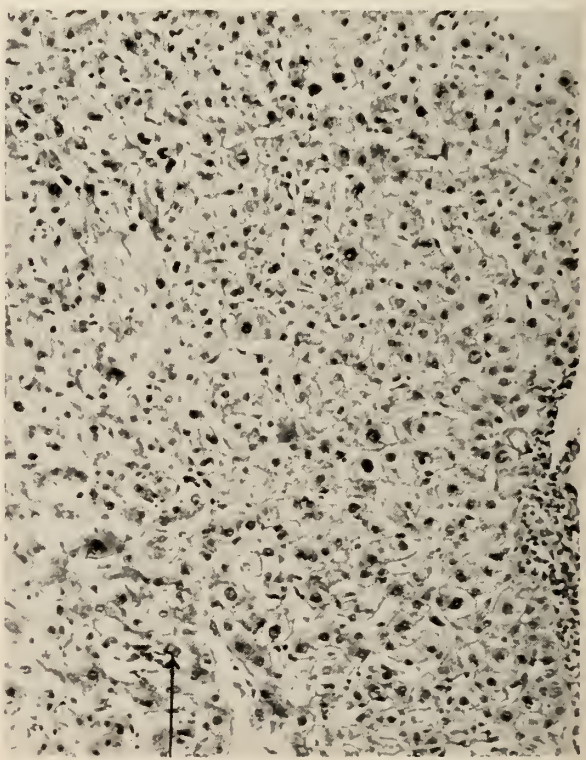


FIG. 1. *This is a photomicrograph of the liver biopsy of June 6, 1960. At the top half evidence of hepatitis may be seen as described in the report. The arrow at the lower portion points to a bile cast in a dilated duct.*

From the Department of Internal Medicine, Jewish Hospital, Cincinnati, Ohio.

Submitted May 16, 1961.

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TABLE 1. *Laboratory Studies*

| 1960 | 5/31 | 6/4 | 6/5 | 6/9 | 6/11 | 6/13 | 6/15* | 7/1 | 7/8 | 7/29 | 8/5 | 8/12 | 8/19* | 9/23 | 10/14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WBC | 5,000 | | 6,000 | 4,900 | | 10,000 | 8,900 | | | | | | | | |
| Diff. | 54-34<br>5-2 | | 12%<br>Eos. | 5%<br>Eos. | | 7%<br>Eos. | No Eos. | | | | | | | | |
| Hgb. | 12.7 | | 12.4 | 12.4 | | 12.4 | | | | | | | | | |
| Platelet Count | | | 275,000 | 210,000 | | | | | | | | | | | |
| Ceph. Floc. | Neg. | | | | | | | | | | | | | | |
| Thymol Turbity | 5.4 | | | | | | | | | | | | | | |
| Prothrombin | 80% | | | | | | 100% | | | | | | | | 100% |
| Alk. Phos. SJR Units | 36 | 36 | | 39 | 42 | | 43 | | | | | | | 20.8 | |
| Cholesterol | 567 | | | | | | 445 | | | | | | | | |
| | 2.9 | 3.1 | | 3.4 | 3.2 | | 3.25 | 3.0 | 3.4 | 2.0 | 2.0 | 1.5 | 0.9 | 0.5 | 0.4 |
| Bilirubin | 6.2 | 6.82 | | 7.97 | 7.0 | | 6.47 | 6.2 | 6.0 | 3.0 | 2.5 | 2.2 | 1.4 | 0.9 | 0.8 |
| SGOT | 216 | 166 | | | | | 269 | | | | | | | | |
| SGPT | 545 | 315 | | | | | 286 | | | | | | | | |
| SLDH | | 355 | | | | | | | | | | | | | |
| Total Prot. A/G | | | 7.6<br>3.6<br>4.0 | | | | | | | | | | | | |

Fasting blood sugar, and blood urea nitrogen were within normal limits. L. E. Prep was neg. X3. Several urinalyses were within normal limits except for a trace of bile on June 5. Occult blood was neg. X3. Electrocardiogram showed nonspecific T wave changes.

*Prednisone was started on June 25 and discontinued on August 19.

abnormality present. A barium enema and upper gastrointestinal series were normal.

A liver biopsy was done on June 6 and reported as follows: "The section exhibits no parenchymal fat. There is a striking centralobular capillary bile stasis and heavy pigmentation of Kupffer's cells. Abundant individual parenchymal cell necrosis is characterized by minute focal collections of lymphocytes and histiocytes. These appear in all portions of the lobule, occasionally bordering on the central vein. Portal areas are slightly enlarged and contain a variable infiltration with leukocytes among which lymphocytes prevail but small numbers of eosinophils and neutrophils are encountered. In the main, parenchymal cells are orderly: in relation to the foci of necrosis however there is a swelling and multinuclearity. The lesion is nonspecific, in many respects it resembles smoldering hepatitis of the so-called 'cholangiolitic type'." Figure 1 is a photomicrograph of the liver biopsy.

The clinical course was one of moderate improvement in well-being after one week in the hospital, but no remission of jaundice was noted until five weeks after the onset. The rash disappeared three days after discontinuation of the medication. Steroids (prednisone 100 mg. daily, tapered down gradually) were begun on June 25, one month after onset of jaundice, and continued until August 19. On October 1, 1960, she returned to work as a pastry cook. She remained nervous, anxious, and occasionally pruritic, but was functioning well. At her last visit on December 19, 1960, the patient was asymptomatic with no more itching, and there was no obvious icterus. She weighed 138 pounds. Surgery for the goiter has been delayed for the time being.

Table 1 summarizes the various laboratory studies showing the progression of this patient's clinical course.

## Discussion

This patient represents a case of hepatitis probably secondary to methimazole therapy. The liver biopsy showed that a centralobular bile stasis was a prominent distrubance. A small number of eosinophils were also present in the biopsy specimen along with a mild peripheral eosinophilia. Perhaps this eosinophilia represented a manifestation of an allergic reaction to the drug similar to that of the promazine group of drugs.[7]

Evidence that the liver involvement in this patient was a manifestation of methimazole therapy is somewhat indirect. However, the clinical history of jaundice for four weeks after institution of therapy, the liver function tests, and the histological features of the liver biopsy exclude viral hepatitis. The laboratory findings and clinical course are very similar to those found in the other choliostatic drugs such as promazine[7] and methyltestosterone.[8,9] This case failed to exhibit the bone marrow depression seen in the other cases of jaundice secondary to methimazole. The time of onset, however, is similar to that of the other three reported cases. The liver biopsy is also similar to the one reported previously, and to the postmortem examination reported.

Hepatitis is an unusual complication of methimazole therapy, but probably not as rare as the paucity of reported cases would indicate.

**Acknowledgment:** We wish to thank Edward A. Gall, M. D., Director of the Department of Pathology, Cincinnati General Hospital, for permission to quote his report of the liver biopsy.

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# Massive Hepatic Hemangioma

## Report of a Case with Successful Surgical Resection

ROBERT J. DIAZ, M.D., FRED F. WHITCOMB, JR., M.D., and
CHARLES H. BROWN, M.D.

TRUE HEMANGIOMAS are thought to be vascular tumors of congenital origin, arising from embryonic sequestrations of mesodermal tissue. They may become malignant, and metastatic lesions, although rare, have been reported.[1] Benign metastasizing hemangiomas have also been described.[2] Hemangiomas occur more frequently in the liver than in any other internal organ;[3] the incidence here is second only to that in the skin and the mucous membranes. In a collective review of 66 cases of hepatic hemangioma, Shumacker[4] reported an age distribution of from 6 to 76 years, with an average of 44 years, and a ratio of 4.5 females to 1 male.

Hemangiomas occur most often in the left lobe of the liver; usually they are single, and they vary greatly in size and shape. The surrounding hepatic tissue is generally not affected by pressure necrosis from the expanding tumor. Since most angiomas are small and innocuous, they seldom produce symptoms. The majority of these lesions are incidental findings at exploratory operations or at necropsies.

Symptoms, essentially those of hepatomegaly, become apparent only when the hemangioma becomes extremely large. The initial symptoms in about half of the patients in Shumacker's[4] series were gastrointestinal symptoms such as nausea, vomiting, midepigastric pain, eructation, bloating, and mild indigestion. The other patients were asymptomatic, but each had a palpable abdominal mass. The duration of symptoms in the 66 patients ranged from 2 to 30 years, with an average of five years.

A positive diagnosis is difficult to make before surgery; only 2 of 66 cases of hepatic hemangioma reported by Shumacker[4] were diagnosed correctly before operation. The presence of an enlarged liver, or of an epigastric mass and an overlying bruit may be of some aid. Roentgenograms may show evidence of a soft tissue mass or evidence of extrinsic pressure in the lesser curvature of the stomach. Laboratory diagnostic procedures, including liver function tests, are usually of no value. Evidence of calcifications in hemorrhagic extravasates may be visible in roentgenograms, but the degree of mineralization is generally slight.[5]

Hemangiomas should never be aspirated or traumatized, nor should specimens be taken for biopsy. The penetration of a needle into the tumor may result in uncontrollable hemorrhage. The preferred treatment is surgical excision; partial hepatectomy produces the best result. Duckett and Montgomery[6] have shown that large portions of the liver can be resected without impairment of hepatic function. In some instances, large tumors that are technically inaccessible may be treated effectively by roentgenotherapy.

Prognosis is affected by the extent, and particularly by the histologic nature, of the angioma. Even in patients with large benign tumors serious complications rarely ensue, although in such patients there is grave danger that trauma to the liver will cause intractable hemorrhage.

The following case report is of interest because the patient had a large hemangioma of the left lobe of the liver which probably was symptomatic for several years before it was recognized and was resected, and because of the question of Vim-Silverman needle biopsy presented by the enlarged left lobe.

### Report of a Case

A 57 year old white woman entered the Cleveland Clinic Hospital on November 20, 1959, because of a long history of intermittent episodes of bloating, intolerance to many foods, and occasional episodes of nausea and vomiting. In 1944, a cholecystectomy was performed at another hospital because of these symptoms. At that time stones were re-

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From the Department of Gastroenterology, The Cleveland Clinic Foundation, and The Frank E. Bunts Educational Institute, Cleveland, Ohio.

Submitted June 7, 1961.

moved from the gallbladder, but the attacks of indigestion were not relieved. The patient had always had a good appetite and had no history of losing weight. The episodes of indigestion were frequently associated with nervousness, headaches, and diarrhea, with as many as nine loose but not bloody stools daily. The indigestion was most severe and frequent for one month before admission to the hospital.

Results of the physical examination were normal except for the presence of a large, ill-defined, nonpulsating tender mass in the epigastrium, which did not move during deep inspirations.

Routine determination of blood hemoglobin and white blood cell counts were normal. Results of the following tests were also normal: urinalysis, serum amylase, serum lipase, serum proteins, blood urea, and liver function, including cephalin-cholesterol flocculation, serum bilirubin, Bromsulphalein, thymol turbidity, glutamic oxalacetic transaminase, and prothrombin time. Results of an intravenous cholangiogram and roentgenograms of the chest and of the colon were normal. Gastric and duodenal roentgenograms were normal except for evidence of what appeared to be a large epigastric soft-tissue mass causing a pressure defect on the lesser curvature and the antral portion of the stomach, displacing the stomach posteriorly. The duodenal bulb and the duodenal loop appeared to be normal. Preoperatively, the most likely diagnosis seemed to be a pancreatic tumor or cyst.

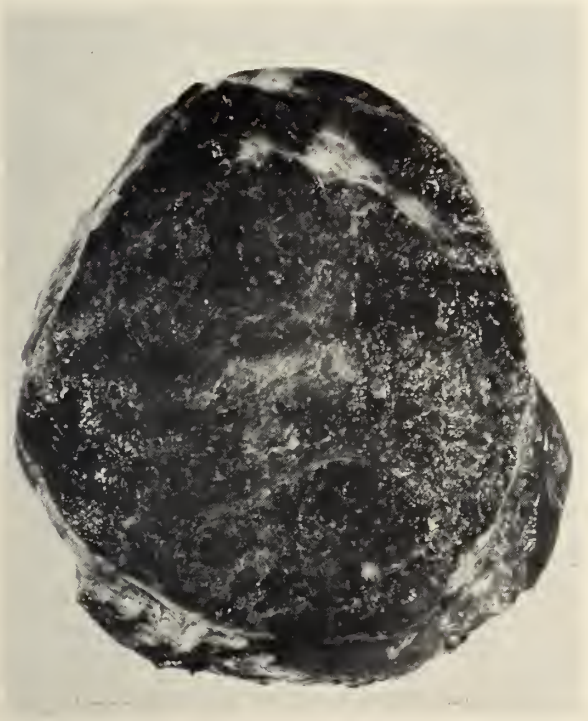


FIG. 1. *Photo of the tumor that replaced the left lobe of the liver (cut surface). The tumor was encapsulated.*

An exploratory laparotomy* was performed on March 9, 1960. The left lobe of the liver was almost completely replaced by a large, well-defined, bluish tumor that was 15 cm. by 11 cm. by 4 cm. and weighed 635 grams (Fig. 1). The tumor and most of the left lobe of the liver were excised. The hemangioma could be shelled out like a cyst, without the bleeding that was anticipated from such a vascular tumor. Sections showed the lesion to be a cavernous hemangioma. Postoperative recovery was uneventful.

The patient was re-examined by us in October, 1960, and again in March, 1961. She was much improved, although the symptoms of indigestion had not completely disappeared. Results of tests for serum bilirubin, alkaline phosphatase, and of the Bromsulphalein test were normal each time.

*The operation was performed by Dr. S. O. Hoerr, Department of General Surgery, the Cleveland Clinic.

## Discussion

The patient originally presented a difficult diagnostic problem. In most patients with hepatomegaly in whom the diagnosis is obscure, we believe that needle biopsy of the liver is indicated.[7,8] We had considered needle biopsy rather than laparotomy for this patient, but because the mass was in the left upper quadrant, representing the left lobe of the liver, and was atypical for cirrhosis or metastatic cancer, laparotomy seemed advisable. Needle biopsy might well have caused serious hemorrhage from the hemangioma. A bruit was not heard over this tumor, but when a bruit is heard, or when a vascular tumor is suspected for any reason, needle biopsy of the liver is contraindicated.

It should be noted that results of liver function tests were normal both before and after the operation, despite the nearly complete replacement of the left lobe of the liver with the tumor. When the hepatic cells present are functioning normally, any depression of liver function by cysts, tumors, or metastatic carcinoma, requires considerable replacement of hepatic tissue (from 50 to 75 per cent). Large cysts or tumors may be present in a liver that is functioning normally.

## Summary

This report presents the case of a 57 year old white woman with a large cavernous hepatic hemangioma, involving most of the left lobe of the liver. The lesion was symptomatic and probably was present for several years. When a hemangioma is suspected clinically, needle biopsy of the liver is contraindicated. Treatment comprised removal of most of the left lobe of the liver. Results of liver function tests were normal both before and after operation and the patient made an excellent recovery.

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● RUPTURED ABDOMINAL ANEURYSMS.—The more important radiographic findings in cases of ruptured aneurysms include: obliteration of the psoas shadow, hazy and indistinct margins of the mass with extension beyond a calcified rim, and displacement of the bowel gas anteriorly on the lateral film. —*The New England Journal of Medicine:* 265:12-15, July 6, 1961.

Heart Page

# The Cerebral Insufficiency States

GEORGE MORRICE, JR., M. D.*

THE Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

1. **What is the importance of the cerebral insufficiency states?** Whereas in former years, it was believed that there was no effective therapy for victims of cerebrovascular accidents, it has become recognized since 1955 that as many as 40 to 70 per cent of these patients may have warning prodromal symptoms of impending thrombosis. Furthermore, about one fourth of the patients with cerebrovascular disease manifestations have extracranial (carotid and vertebral-basilar arteries) occlusive disease. Transitory episodes of hemiplegia and related symptoms were once ascribed to cerebral vasospasm; however, there is much evidence to indicate significant cerebral vasospasm does not exist.

2. **What is the clinical picture of the internal carotid artery insufficiency state?** The patient has a transient attack, of sudden onset, of unilateral muscle weakness or sensory changes with a complete clearing between attacks. One side of the body is consistently involved in the episodes and the same type of attack is often repeated. If the dominate side of the brain is involved, aphasia may be present. There may be involvement of vision homolateral to the affected artery. There is no associated convulsive activity or loss of consciousness. The differential diagnosis of the transient cerebral ischemic attacks, including their correct localization, is often difficult by clinical means alone.

3. **What physical finding should be searched for in internal carotid artery insufficiency state?** In addition to the positive neurological findings present during an acute attack, there may be noted an absence of carotid pulsation in the neck: minor differences of pulsation in the two sides of the neck are not reliable and the pharyngeal pulsations are not helpful. A bruit infrequently may be heard with the bell of the stethoscope over the common carotid bifurcation in the neck, or over the eyeball. Lowered blood pressure in the ophthalmic artery (and thus in the internal carotid artery on the same side) may be detected by means of an ophthalmodynamometer.

4. **What is the clinical picture of the vertebral-basilar artery insufficiency state?** The patient has a transient attack, of sudden onset, with bilateral involvement, with a complete or almost complete clearing between attacks. The signs may shift from one side to the other and there may be bilateral visual defects with blurring, blindness, diplopia, or nystagmus. The patient may have dysphagia and dysarthria, vertigo, mental confusion, paresthesias in the face or on one side of the body; there may be hemiparesis or hemiplegia and the patient may lapse into unconsciousness. The same symptoms on opposite sides of the body in definite attacks, suggest the diagnosis.

5. **In what type of situation should one consider the advisability of performing reconstructive surgery for stenosing and occluding lesions in the carotid arteries?** If there is stenosis of an artery which can account for the patient's symptoms, and the patient is neurologically intact or has only a mild stable deficit, this situation is most favorable for surgery. If a short, segmental occlusion is found by arteriography and the patient has either intermittent symptoms or a mild and stable deficit, then surgery is advisable. Every patient with actively progressing cerebral infarction constitutes an emergency. He should be given an immediate intravenous injection of heparin and arteriography arranged.

6. **What part does arteriography play in the diagnosis of patients with cerebral insufficiency states?** It is desirable to have arteriographic studies of all patients who are considered for surgery. Such studies carry certain inherent risks and these risks are greater in patients with atherosclerosis of the cerebral vessels. Radiographic visualization is also advisable in those patients in whom other diagnoses are possible.

7. **In what cerebrovascular diseases are anticoagulants of value?** The cerebral insufficiency states (vertebral-basilar and internal carotid arteries); progressive thrombosis of the basilar, internal carotid, or middle cerebral arteries; cerebral emboli (atrial fibrillation, myocardial infarction with mural thrombus, chronic rheumatic heart disease with normal sinus rhythm). Immediate heparinization is indicated in patients who, when initially examined, show signs and symptoms of the cerebral insufficiency states with progressive thrombosis of these systems, or of the intracranial arteries.

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# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

HORACE B. DAVIDSON, M. D., *President*

### PRESENTATION OF CASE

A 21 year old male Negro was admitted with a 4-day history of migratory joint pain which began in his right wrist and left ankle. Three days prior to admission the pain was felt in the left elbow and both knees, and on the day of admission was noted in both elbows, ankles and knees. He was not aware of heat or discoloration of the joints and had not noted swelling at any time. He had had a mild fever for this 4-day period, for which he had taken aspirin. One day prior to admission he developed a sore throat which was painful on swallowing and was associated with a dry, hacking cough. On the same day he developed arthralgia in the low back region. His past medical history and review of systems were noncontributory.

#### Physical Examination

The blood pressure was 110 over 70, pulse rate was 80 per minute and regular, respiratory rate 20 per minute, the temperature 100.6° F. His posterior pharynx was markedly injected but there was no exudate present. Submandibular nodes were palpable bilaterally. The chest was clear to percussion and auscultation. The heart was not enlarged to physical examination; the heart rhythm was regular and the heart sounds were of normal intensity. There was a blowing apical systolic murmur radiating to the left axilla; a harsh systolic murmur was heard at the base with radiation to the neck.

The liver could be felt at the right costal margin; it was not tender, and the edge was smooth. There was tenderness to palpation in both flanks. The left wrist, both knees and both ankles were warm to touch and were painful on passive motion; there was no swelling in these joints and no redness of the skin. The remainder of the physical examination and the neurological examination were within normal limits.

#### Laboratory Data

The hemoglobin was 12.2 Gm. with 37 per cent hematocrit; the red blood cell count was 4.07 million, the white blood cell count 13,700 with 72 per cent polymorphonuclear leukocytes, 28 per cent lymphocytes. The sedimentation rate was 24 mm. in one hour. Urinalysis showed a specific gravity of 1.020, no protein or sugar; the sediment contained 10 to 15 red blood cells per high power field. The blood sugar at the time of admission was 73 mg., the blood urea nitrogen 12 mg./100 ml. The antistreptolysin titer was 166; Latex fixation was negative; C-reactive protein was 2 plus. A hemoglobin electrophoretic pattern showed 100 per cent A-type hemoglobin.

Multiple lupus erythematosus preparations were negative throughout his hospitalization. Heterophil agglutination was positive in 1:14 dilution, febrile agglutinations were negative. Multiple blood cultures drawn at admission and throughout the remainder of hospitalization remained negative. Bromsulphalein test showed 2.5 per cent retention of the dye at the end of 45 minutes. The serum transaminase on admission was normal. The serum calcium was 8.4 mg./100 ml., the alkaline phosphatase was 8.9 units. Throat cultures grew a normal flora only.

#### Hospital Course

On admission it was thought that the patient possibly had acute rheumatic fever, and he was started on therapy with penicillin and salicylates. An electrocardiogram taken on admission and subsequent tracings obtained during hospitalization showed a suggestion of left ventricular hypertrophy and nonspecific ST segment changes. Penicillin and salicylates were continued for the first two days of hospitalization, during which time his temperature ranged between 100 and 103° F. On the day following admission he developed lacrimation, photophobia and conjunctivitis of both eyes. Culture obtained from the conjunctiva of the left eye grew out a coagulase-negative

### *Presented by*


- **Eugene A. Stead, M. D., Durham, N. C., Department of Medicine, Duke University, and**
- **Emmerich von Haam, M. D., Columbus.**

**Edited by Dr. von Haam.**


Submitted December 29, 1961.

*Staphylococcus* and an *Achromobacter*. The C-reactive protein had risen from 2 to 4 plus. The sedimentation rate was 30. He continued to complain of diffuse migratory arthralgia, and on the fourth hospital day he also began complaining of diffuse muscle tenderness.

On the seventh hospital day salicylate therapy was reinstituted and continued throughout the remainder of his stay. On the same day penicillin and streptomycin therapy was reinstituted and continued through the sixteenth hospital day. During this course of therapy his temperatures varied from normal to 100° F. He continued to have arthralgia and muscle tenderness. His conjunctivitis progressed and on the seventh hospital day bilateral corneal ulcerations were seen. Cultures from the urethra obtained on the fifth hospital day grew out a coagulase-negative *Staphylococcus*.

Despite feeling relatively well, the patient continued to have his joint symptoms and muscle tenderness and in addition progressively developed more lymphadenopathy, primarily in the cervical and axillary regions, and he was also noted to have epitrochlear nodes. Latex fixation became positive at 1:160. A biopsy of an epitrochlear node showed a nonspecific lymphadenitis. A muscle biopsy from the extensors of the right forearm was interpreted as normal muscle. He continued to run a mildly febrile course which on the eighteenth hospital day became more severe and continued until his death, with spiking temperatures in the range of 102 to 103°.

The possibility of septicemia was repeatedly entertained and numerous blood cultures were taken and remained negative. On the seventeenth hospital day the spleen could be felt at the left costal margin for the first time. Coincident with this, one observer felt that here was a definite change in the character of the murmur heard at the apex, becoming coarser than previously. A second lymph node biopsy from the axilla was obtained and again showed nonspecific lymphadenitis. Bone marrow examination was consistent with response to infection and bone marrow cultures were negative. Throughout hospitalization antistreptolysin titers were measured at intervals; the highest recording was 250 units as compared with the initial value of 166. During the latter two thirds of hospitalization the white blood cell count remained low, in the neighborhood of 3200 to 4800 cells per cu. mm. with a normal differential count. The level of serum glutamic oxalacetic transaminase, which had been normal on admission, began to show a progressive rise beginning on about the sixteenth hospital day, at which time it was 212. This progressively rose to a peak of 1410 on the twenty-fifth hospital day.

Triple sulfonamide therapy was started on the twenty-fourth hospital day. On the thirtieth hospital day he had an episode of epistaxis and a single bout of hemoptysis. At this time also it was felt that he had a moderate degree of stiffness of the neck. A lumbar puncture was done with normal cerebrospinal fluid findings on examination. Two days prior to his death he had the abrupt onset of massive gastrointestinal hemorrhage which did not respond to 10 units of blood. He was taken to surgery and a 90 per cent gastrectomy was done.

Postoperatively the bleeding continued. He failed to respond to blood replacement and continued to be mildly hypotensive. It was felt that he was bleeding from his incisional site, and he was re-explored. Blood was found to be oozing from the surface of all viscera and the peritoneum. No single site of massive bleeding could be demonstrated. The incision was closed without effective therapy, and the patient died shortly thereafter without ever responding to fresh whole blood transfusions.

## CLINICAL DISCUSSION

DR. STEAD: Our patient was a young man, who had arthralgia involving multiple joints. He had a fever, a sore throat, and physical examination revealed murmurs in his heart. I am certain that the people who admitted him felt that he had a conventional case of rheumatic fever. His throat culture did not grow out any significant organisms, although it is not known whether this man had received any antibiotic therapy beforehand. If he met any druggist, pharmacist, nurse or doctor he probably had had some antibiotic therapy. This of course leaves us with a clinical problem without an immediate answer, but it seems most reasonable to assume that he did have acute rheumatic fever, and therapy was instituted in this regard. He was treated with both penicillin and salicylates.

### Old Rheumatism?

He had the usual kind of laboratory data, which were not tremendously helpful, and the murmurs were not actually diagnostic of any particular lesion. They certainly did not suggest congenital valve disease. The murmurs raise the question of whether this man had lesions of the aortic valve and of the mitral valve, which would certainly most likely fit into this story. We are not given any information as to whether he had ever had any active rheumative fever previously, and the present disease was of course of too short duration for him to have really developed an aortic murmur on an organic basis. But he could well have had rheumatic fever without a clinical history. Indeed half of the patients whose various valves we ask the surgeons to fix up don't give a clinical history of rheumatic fever, although we suspect it on the basis of the pathological findings.

The urine examination might raise the question of whether this presumable streptococcus which was causing the trouble in the joints and in the heart had produced any kind of reaction in the kidneys. He had fever, a positive sedimentation rate, C-reactive protein, and these kinds of reactions fit with the fact that his disease at least was eliciting an inflammatory response. He was not leaking any enzymes from his

cells when he came in, since he did not have an elevated transaminase. The report of his electrocardiogram states that he had left ventricular hypertrophy. Dr. Ryan and I agree that this means that this illness did not date from the time at which the protocol says it dated but from an earlier time.

The first alerting sign of trouble came when the conjunctivae became involved. Clinical experience teaches us that when, in a man with fever, a heart murmur, and arthralgia, an explosive inflammatory reaction of the eyes sets in it is apt to become a grave illness. Our patient developed lacrimation, photophobia and conjunctivitis in both eyes. Now his doctors worried about a gonococcal infection, which he did not seem to have, and sarcoid, which he might or might not have had. They worried about all kinds of diffuse inflammatory disease grouped together as collagen disease, and repeated lupus preparations were examined, all of which were negative.

### Drug Reaction

The question also came up as to whether or not he had a drug reaction and for this reason his penicillin was discontinued. It is the kind of people who have arthralgia and fever and inflammation of the eyes which do have drug reactions, and we don't think the drug reaction is so terribly important except insofar as it reveals the type of patient we are dealing with. It would make us think maybe this is the wrong host for whatever disease he had. Of interest also is the fact that in spite of his muscle tenderness, which was very prominent through this whole illness, the muscle biopsy was negative. I hope they biopsied a sore muscle, and not the easiest one to reach, in order to rule out dermatomyositis.

### Bacterial Endocarditis?

The question of course came up as to whether he had bacterial endocarditis, and as you know, this is a difficult diagnosis to make. With all these heart murmurs and the provisional diagnosis of rheumatic fever he had a good background for it. He had a whole series of blood cultures taken during his hospital stay and all these cultures were negative. This isn't very helpful because bacterial endocarditis many times does have negative cultures. I was curious whether he ever had any really massive antibiotic therapy. If he was given a large quantity of penicillin and streptomycin over a period of time and got no better at all, I would be willing to eliminate this diagnosis in the presence of his negative blood cultures. We are just left with the fact that he could have bacterial endocarditis. I don't think he did, but there is no way that I can be absolutely certain about it.

During his illness he began also to show some involvement of the lymphatic system. He had a few submaxillary nodes when he came, and his other nodes became a little more prominent during his hospitalization, together with a palpable spleen. This raises the problem of what might have happened to his reticuloendothelial system. He could have reticuloendotheliosis or any type of lymphoma including Hodgkin's disease. However, two biopsies from some peripheral nodes could not be interpreted in a definite manner, which by no means rules out lymphoma in the earlier stages of its development.

### Significance of Changing Murmur

In the course of his illness he was said to have some change in his heart murmur. In our experience this has not been a commonly helpful phenomenon since many things can change a murmur — fever, tachycardia, position, the attentiveness of the doctor — besides bacterial endocarditis. He also showed signs that he was having a diffuse injury of some type to his body cells since they began to leak enzymes as evidenced by the rising transaminase level in his blood. This does not help us to recognize specifically what cells have been hurt, but it does mean that his disease has become severe enough to produce diffuse cell injury.

### Unexplained Hemorrhage

Then he began to bleed. They gave him a lot of blood but he continued to bleed and did not stop. So he was taken to surgery and had a 90 per cent gastrectomy. I do not know whether this means that they discovered a lymphoma in his stomach which they removed, or just what kind of thinking went into this operation. Then obviously they tried to keep on giving him blood, and by this time I guess his whole clotting mechanism was distorted as the more blood put into him, the more he bled. I don't know whether he started to bleed because of drugs or on account of his disease, or maybe because of the 10 transfusions he had before surgery. He finally developed intractable shock and died.

We have the problem now of how to put it all together. I am inclined to say that he had something wrong with his heart previously, and I am inclined to believe that the murmurs he had were murmurs of old rheumatic heart disease. I actually don't know what happened to him at the time he was admitted. I don't think he had bacterial endocarditis, and I rather doubt that this was sarcoid. I rather doubt that he had a tumor, even though he had these diffuse disturbances in his connective tissue of the type of dermatomyositis which are known to occur in many primary neoplasms. I am not inclined to think he had tuberculosis, which frequently develops in this kind of patient as a secondary infection.

Since he had been ill long enough and had had much antibiotic therapy with depression of his white blood cell count, he could have had any kind of secondary invaders such as fungi, but I don't think any of this was fundamental to our particular problem, and I would guess we have before us a patient who aroused a large amount of discussion while he was in the hospital and for whom nobody had a definitive

diagnosis. I guess that the pathologist will be able to make certain contributions and give us certain structural information, but I doubt whether he will be able to explain the complete etiology of this patient's illness. This is the kind of thing that happens to doctors who take care of sick people, and everyone of us goes through the same experience. We think at first that the patient is not too sick, and when he gets too sick we do a lot of tests and cannot reach a complete diagnosis. The pathologists do the best they can but they also will not always have a complete explanation.

### Collagen Disease

My guess is that his disease could be classified as collagen disease, and I rather think with his transaminase levels that he will show lesions in the muscles. It is perfectly possible that he could have discrete blood vessel lesions. It is perfectly possible that he will just have a lot of thrombi. It is perfectly possible that the pathologist in spite of the normal platelet count may wonder if he had thrombotic thrombocytopenic purpura, in which the platelets agglutinate in the blood vessels due to the abnormalities in the blood vessels and you have got a lot of little thrombotic phenomena. These are all possibilities, and I have the feeling that we have not missed a clearly diagnosable disease which the surgeon or the internist could cure.

I have learned from experience that a lot of people are smarter about these things than I, and since I did not want an inattentive audience while I was talking I alerted Dr. Schieve and Dr. Ryan that I wanted to know what they thought.

### General Clinical Discussion

DR. SCHIEVE: I do not think he had rheumatic fever.

DR. STEAD: Then Dr. Schieve and I take different stands on the heart valves. I think these will show pathology which will be interpreted as old rheumatic fever.

DR. RYAN: I think he had bacterial endocarditis.

DR. STEAD: You mean you are agreeing with me that he had had rheumatic fever at one time? You are going to be on my side and against Dr. Schieve? Dr. Zollinger, this is a problem in which the surgeons were concerned.

DR. ZOLLINGER: I don't think that there was any specific cause of his bleeding. I think it was part of his over-all disease. If his heart was big before the illness started, I would assume that it was due to heart disease. I don't think you will find the cause. It will be a long-standing, weird and unsavory infection.

DR. STEAD: Dr. Warren, maybe we had better ask your opinion.

DR. WARREN: I am afraid I can't do any better. I thought probably he had some small blood vessel disease, not really lupus, maybe associated with thrombotic thrombocytopenic purpura. This brings up the clinical picture that some people have recently described as macroglobulinemic syndrome. These people get small vessel thrombotic lesions and they also get bleeding tendencies at times. Dr. Saslaw made an excellent suggestion that since he had intensive salicylate therapy the diffuse bleeding from his stomach could be related to that.

DR. STEAD: I think it is a good suggestion. One other question: In a diffuse kind of illness in a young individual there is the possibility of trichinosis with involvement of the myocardium and a lot of emboli. Does that appeal to you at all?

DR. WARREN: I don't think so. My final point is that I don't think the pathologists will know either.

DR. MACPHERSON: I was fortunate enough to see this patient on about 15 occasions before he died—first of all in consultation bacteriologically and secondly, "blood-bank-wise." Multiple cultures were taken before he received antibiotic therapy, and it has been our experience in the cases of bacteriologically proven bacterial endocarditis we have reviewed that if you have one culture taken before therapy your accuracy of diagnosis will be about 40 per cent, if you have two cultures it will be about 65 per cent, and if you have three or more cultures it will be 93 to 94 per cent. So we thought on that basis we could exclude with a high degree of confidence most of the conventional bacterial diseases. The second point was that when the bleeding started we felt that the salicylate was the most probable etiological factor of the bleeding, and when it continued after surgery we felt that it was on the basis of a severe disturbance of his coagulation mechanism.

#### CLINICAL DIAGNOSIS

1. Old rheumatic heart disease.
2. Some type of collagen disease.

#### PATHOLOGICAL DIAGNOSIS

1. Septicemia of undetermined origin.
2. Severe generalized hemorrhagic diathesis.
3. Gastrointestinal hemorrhage and hemoperitoneum.

#### PATHOLOGICAL DISCUSSION

DR. VON HAAM: I shall discuss first the pathology of the various specimens removed surgically. Examination of the muscle biopsy revealed no evidence of disease. Examination of the lymph node showed a nonspecific and probably subacute lymphadenitis. Examination of the resected stomach showed many areas of superficial hemorrhage originating mostly in the mucosa. In one area a wedge-shaped necrotic infarct was noted with numerous colonies of Gram-positive organisms in the infarcted area and the adjoining blood vessels. Sections through the spleen showed congestion with evidence of acute hemolysis as often seen in this organ after repeated blood transfusions. The Malpighian corpuscles showed massive

cellular necrosis with destruction of the germinal centers and evidence of necrobiosis and phagocytosis.

At autopsy, the abdominal cavity contained approximately 1500 cc. of sanguineous fluid with numerous blood clots in the splenic region. Both pleural cavities contained 2000 cc. of sanguineous fluid. The heart weighed 325 Gm. and appeared perfectly normal grossly. The left ventricle measured 15 mm. in thickness and the leaflets of the valves were thin, smooth and flexible. The lungs were heavy with fluid but showed no areas of consolidation. The liver showed a large subcapsular hemorrhage. The organ was soft and brown. The small and large intestines contained approximately 1000 cc. of blackish-red fluid. The other gross findings were not remarkable.

*Microscopically*, there was a spotty accumulation of inflammatory cells in the myocardium, not sufficiently characteristic to make a diagnosis of rheumatic fever but of the type seen in many infectious processes including viral infections. Sections through the lung showed the alveoli filled with clear fluid, a picture seen in severe shock. Sections through the liver showed large areas of confluent intralobular necrosis with moderate leukocytic reaction. Section of the gastrointestinal tract showed mild hyperemia with no evidence of recent hemorrhage. The adrenals presented the picture of complete lipid depletion. In the kidney hemoglobin casts were found in distended tubules, compatible with a kidney in a patient who had had numerous blood transfusions. Sections through the patient's lymph nodes showed extensive areas of necrosis similar to those observed in the surgically removed spleen. There was extensive phagocytosis of nuclear fragments by the remaining reticuloendothelial cells. Similar changes of necrosis were also present in the bone marrow. Sections through the cornea showed a hyaline scar without evidence of inflammation. Bacterial cultures performed at the time of autopsy showed a coagulase-positive *Staphylococcus* which we considered a terminal complication. There was no chemical evidence of azotemia. The joints were not examined.

*In summary*, I feel that this patient demonstrated three processes: He had a mild myocarditis which was not specific for rheumatic fever, presented evidence of toxic irritation of his stomach with mucosal hemorrhage, and evidence of an unknown infection which produced hemorrhagic and necrotizing lesions in spleen, liver and lymph nodes. The process resembles that of the hemorrhagic septicemia in mice produced by the group of pleuropneumonia organisms. The only time we saw histological evidence of microörganisms was in the stomach, but they must have exerted a tremendous cytotoxic effect. In addition the patient presented the picture of shock probably caused by severe blood loss. We do not think, however, that shock alone could be responsible for the cytotoxic change in the parenchymatous organs. There was no histological evidence of collagen disease, including thrombotic thrombocytopenic purpura. I feel that the cytological changes in the liver, spleen and bone marrow explain fully the tremendous rise in transaminase levels in the patient.

*In conclusion*, I believe that the patient suffered from a severe, unidentified and very cytotoxic infection complicated by salicylate intoxication and shock due to hemorrhage.

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**NITRITES IN BRONCHIAL ASTHMA.** — Separate tests of sublingual nitroglycerine and sublingual erythrityl tetranitrate resulted in subjective improvement and increased 1 second timed vital capacity. Tests in two patients showed that 0.6 mg. of nitroglycerine is equally effective whether administered orally or sublingually; the authors have found that both nitrites are as effective orally as sublingually in patients with cardiovascular disease.

Six patients were then tested with 15 mg. erythrityl tetranitrate, 0.3 mg. nitroglycerine, and 15 mg. isoproterenol, all given by the sublingual route. They were evaluated by closed spirometry methods and 1 second timed vital capacities. The time of onset of action was usually within 10 minutes with all three drugs. The maximum effect averaged 20 minutes for nitroglycerine and for isoproterenol and 45 minutes for erythrityl tetranitrate. The duration of action was one to three hours with erythrityl tetranitrate, 45 to 90 minutes with nitroglycerine, and 20 to 45 minutes with isoproterenol.

In none of these six patients was the peak effect of isoproterenol upon vital capacity greater than that of the nitrites; it was often lower. — *Abstract:* Irving Hirshleifer, M. D., Woodmere, N. Y., and Yogesh Arora, M. D., Brooklyn: *Diseases of the Chest*, 39:275-283 (March) 1961.

# Maternal Deaths Involving Ruptured Uterus

By the OSMA COMMITTEE ON MATERNAL HEALTH

FOR the purpose of teaching, it has been found advantageous to classify rupture of the pregnant uterus as (a) spontaneous or (b) traumatic, when the organ has not been subjected to some surgical procedure previously. Under the latter classification this column published three cases of maternal deaths following version and extraction (Ohio State M. J., 57:547, May, 1961). Herewith, the Committee presents three additional cases, maternal deaths due to *spontaneous* rupture of the "non-scarred" uterus during labor. All three cases present somewhat different problems, although none reveal significant external signs of the fatal hemorrhage.

## Case No. 362

This patient was a 29 year old, white, Para III, cesarean I, who died 19 hours postpartum (post-cesarean). Her past history was not remarkable, and she had not had previous surgery. Three term pregnancies were delivered at term; the only complication was some benign hypertension manifested during the third pregnancy. With her fourth pregnancy the patient consulted her physician three times, in the second, seventh, and eighth month, respectively; the blood pressure reached a high of 146/110 but responded to therapy.

On October 1 (36 weeks) the patient reported vaginal bleeding, was hospitalized and placed at bed rest. The bleeding subsided; x-ray pelvimetry report was that "the head is probably larger than normal but is not impressive," (see later report). On discharge October 6 the patient was instructed to return to the office in a week; three and one-half weeks later her husband called to announce his wife had begun labor. She was admitted October 27 (at term), in labor, the presenting part high, cervix 2-3 cm. Demerol®, Phenergen®, and scopolamine were given. Four hours later (4:20 a. m.) labor was still active, the fetal heart was not heard, and a vaginal examination revealed the presenting part high, the cervix thin and 4 cm. dilated, with a small amount of bleeding. Intravenous fluids were administered; (the quality of uterine contractions was not recorded).

At 5:30 a. m. the patient developed vascular collapse. Oxygen, Wyamine® and intravenous fluids were continued. Consultation was obtained at 6:15 a. m., blood was ordered, venous cut-downs were made and additional fluids started, following which the patient seemed to improve. Whole blood (1 unit) was administered at 7:05 a. m., followed by 3 more units and 2 units of fibrinogen at 9:00 a. m. A classical cesarean section was done at 9:30 a. m., delivering a term-size hydrocephalic, dead fetus. There was a hemoperitoneum estimated to be 1500 to 2000 cc. with a large laceration in the left side of the uterus extending down into the vagina.

The cesarean operation was followed by a (subtotal) hysterectomy and left salpingo - oopherectomy. Considerable oozing accompanied the procedure, but hemostasis eventually was satisfactory. Two more units of blood were given during the operation, and two more had been given by 12:15 p. m. At 1:00 p. m. the patient responded to questions, but the systolic blood pressure was only 76 mm. Another unit (the tenth) of whole blood was administered at 12:30 p. m. in view of continuous vaginal bleeding. There was a urinary output of 30 cc. at 3:00 p. m., by which time the patient had become restless; Demerol and phenobarbital were given.

At 12:45 p. m. the systolic blood pressure was recorded at 120 mm. systolic; a convulsive seizure occurred, with another following at 2:15 p. m. During this interval the systolic blood pressure remained stabile at 125-136 mm. After 2:30 a. m. the patient failed to respond, had a large amount of dark red-brown emesis, pursued a downhill course and died at approximately 3:00 a. m. Autopsy was obtained; (after necropsy, the radiologist reviewed the x-ray films to report "definite, unequivocal hydrocephalus").

*Pathological Diagnosis:* Passive congestion of lungs; mild coronary atherosclerosis; infarct of kidney; laceration of uterus, and focal necrosis of the liver.

## Comment

Members of the Committee commented on the completeness of the records in this case. Several points were exposed for discussion: (1) In spite of the radiologist's "green light," four or five hours of good labor, the head remaining "high" in a "multip," a suspicion of disproportion must be experienced; (2) consultation at that time would have been appropriate; (3) what did the consultant advise at 6:15 a. m.?; (4) when did uterine contractions stop?; (5) it seemed reasonable that total hysterectomy would have been worth the risk, since the "vaginal laceration" (which eventually continued to bleed) would have been discovered and secured earlier. In spite of the 10 units of blood, two units of fibrinogen and a liter of fluid, the circulatory collapse provided an irreversible shock. The Committee voted this a preventable maternal death.

## Case No. 381

This was a 35 year old, white, Para V, who died two hours postpartum. In her past history she had had only a cholecystectomy; there were four previous term pregnancies delivered at term, the fetuses varying in size from 7 to 10 lbs. During her fifth pregnancy she registered with her physician in the seventh month, making six prenatal visits. She was very obese (260 lbs.); an attempt was made to control her weight, also the "mild hypertension" (170/110), albuminuria, and edema, which developed in the 38th week.

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

The records indicate "x-rays of the pelvis taken one week, and four hours prior to delivery were normal."

Spontaneously at term on March 29, labor commenced, the membranes ruptured and the patient was admitted to the hospital at 9:00 a. m. Details of examination during labor are not recorded. However, at approximately 2:10 p. m. the (prolonged) delivery of the infant began. Records reveal that five physicians contributed their efforts to complete the delivery! First, a large fetal head was delivered with (difficult) low forceps, following which the shoulders could *not* be delivered. Finally, utilizing fetal destructive procedures, the delivery was accomplished; reconstructing the dead fetus, its weight was 11 lbs. 13 oz. Demerol® and scopolamine were given during labor. Gas-oxygen-ether anesthesia was given by a physician for one hour and 20 minutes for the delivery.

Immediately following delivery, the patient was reported in good condition (no details on examination of birth canal; blood loss not mentioned). Gradually, the blood pressure dropped, the patient became "shocky." Whole blood and intravenous fluids were given (quantity not mentioned), but in spite of therapeutic efforts the patient pursued a downhill course and died at 3:50 p. m. Autopsy was permitted.

*Cause of Death (Certificate):* Concealed abdominal hemorrhage; pregnancy, difficult delivery; obesity; cephalopelvic disproportion; hypertension.

*Pathological Diagnosis:* Ruptured lower uterine segment with intraperitoneal hemorrhage postpartum; hypertensive heart disease; adenoma, right adrenal gland; fatty cirrhosis of liver; pulmonary atelectasis and hyperemia.

### Comment

The Committee was hampered in the complete study of the case, by certain details in the record, obvious by their absence. Obviously, the patient applied for prenatal care too late. Records do not indicate any studies to rule out pre-diabetic state, in this obese patient with a history of "big babies." Members were puzzled at the radiologist's report of his examination of the pelvis, viz., "normal"; how large did *he* think the baby was? Could he see it through the obese abdomen? The most uniform opinions of the Committee centered on omission of thorough examination of the birth canal after such a difficult delivery. The Committee, after a prolonged discussion, voted this case a preventable maternal death.

## Case No. 463

This patient was a 34 year old, white, Para III, who died three hours postpartum. Her past history was reported to be uneventful. Two term infants were previously delivered; the details and birth weights are not known. Nor are specific facts of her prenatal course available; apparently she had six visits to her physician. Her estimated date for delivery was not recorded; however, on December 9 (near term?) she was admitted for induction of labor. This failed, so the patient was discharged. The record does not reveal laboratory or x-ray studies performed during the admission.

The patient was re-admitted December 30, in early labor, which became established at 10:30 a. m. Soon she was taken to the delivery room, where examination revealed complete dilatation of the cervix, and the "head was in a transverse position," and "high"; it was also felt that the fetal head was large! "Pituitrin® was given — the head did not descend." The cervix was completely dilated. Mid-forceps were applied — it was impossible to deliver the head! Consultation was requested. A cesarean section was considered but decided against due to prior attempt at delivery by forceps. Final decision was in favor of "a podalic version and deliver this baby alive"; the fetal heart was still present (time not stated). Version was attempted, delivering the breech and fetal thorax, but "exceedingly broad shoulders" became arrested, then the after-coming head was impinged and could not be delivered even with "extreme pressure" *exerted* on the *abdomen*. The fetal heart tones disappeared. Then "fetal head was compressed by manual pressure of the hand of the operator inserted into the uterus, and finally delivered." The dead infant weighed 8 lbs. 8 oz.

No vaginal bleeding appeared; there were no details about the third stage, but "the cervix was inspected and no tears were found." A second degree perineal laceration was repaired, all of this under open drop-ether anesthesia, administered by a physician. Transferred to her bed, the patient seemed to be in good condition, with minimal vaginal bleeding. She talked to her husband. Soon afterward at 2:40 a. m. the patient was in complete shock, with no pulse or blood pressure obtainable. Venous cut-downs, bag-breathing and cardiac massage were of no avail; the patient died. Autopsy was permitted.

*Pathological Diagnosis:* Large, complete cervical tear extending into broad ligament; hematoma and rupture of broad ligament; puerperal uterus.

### Comment

With regret in the absence of details in the report, the Committee studied facts in this case. It seemed that the size of previous babies at birth, and pelvimetry of some type would have been a helpful key to the physician when the patient "went over" her due date; no note is available concerning station and estimated size of the fetus when medical induction was attempted December 9. Members felt that (failed) forceps constituted an error with the "head high," although the record indicates "mid-forceps" were applied. The administration of Pituitrin was helpless and hazardous. It is obvious that heroic physical efforts were expended by all present, even the application of "extreme pressure" on the abdomen, which undoubtedly traumatized the uterus. Furthermore, members were puzzled to explain how the after-coming head could be "compressed" by the operator's hand inserted "up into the uterus" — at this point, with a dead fetus, dismemberment and craniotomy might have been advisable to prevent further trauma from the operator's hand. It was felt that the birth canal was not thoroughly examined after this traumatic delivery. Obviously, the operator missed a cervical laceration, which terminated in fatal (concealed) hemorrhage. The Committee, after long discussion, voted this a preventable maternal death.

### Comment of Consultant

The following comment of a consultant, who is a specialist in obstetrics and gynecology, was furnished at the request of the Committee:

"Rupture of the uterus is a formidable complication of labor which, if unrecognized or if recognized only after shock has ensued, carries an extremely high mortality rate.

"A short discussion of the etiology of uterine rupture is important because this serious complication can be prevented if its causes are well understood. Obstructed labor is one cause of rupture of the uterus. Labor may be obstructed by an abnormal presentation such as a transverse lie or shoulder presentation. Obstructed labor with associated overdistention of the uterus can occur in multiple pregnancy, particularly in which one twin obstructs the descent of the other. This may be the cause for

spontaneous rupture of the uterus. Uterine rupture may complicate obstructed labor from cephalopelvic disproportion, whatever the cause may be; contracted pelvis with a normal infant in normal position, an abnormal presentation due to deflexion attitude in a normal pelvis or a disproportionately large head as seen in hydrocephalus.

"Ruptured uterus may have its etiology in a scar in the uterine wall from previous cesarean section or myomectomy. Another, and perhaps as common as any cause of uterine rupture, is intrauterine manipulation or operative forceps delivery. Version and extraction is an extremely common cause of rupture of the uterus. The decomposition of a frank breech is another fairly common cause of lower uterine segment laceration. Difficult mid forceps operation may cause deep laceration of the lower uterine segment. This may be due to improper application of the forceps or actual trauma by the attempt at forceps delivery. Under no circumstance is a *failed* forceps operation per se a *contraindication* to cesarean section. Injudicious use of oxytocics in labor may be a cause of uterine rupture.

"Early diagnosis of uterine rupture is extremely important because of the previously mentioned high mortality rate in the undiagnosed condition. It is becoming more and more the opinion of authorities in obstetrics that intrauterine examination of the uterus should be a routine procedure following *all* vaginal deliveries. No matter what the feeling is in regard to routine post-delivery intrauterine palpation, it is very *definitely indicated* following *all* deliveries involving intrauterine manipulation, following *all* deliveries in all patients who have had a previous cesarean section or myomectomy, in *all* cases of difficult forceps or operative delivery and/or destructive operations upon the fetus. If this is done, and a rent in the uterus is found, corrective measures can be undertaken before the patient's general condition has changed.

"Operations performed on patients who are not adequately prepared is the other factor that increases maternal mortality. Under no circumstance should an anesthetic be started or a surgical procedure undertaken with the patient in shock. Blood replacement must be adequate, the patient's general condition must be improved to the point that her blood pressure is at least 80 mm. systolic and her pulse rate below 100 per minute before an operative procedure is begun. This must be accomplished, if necessary, by pressure transfusion and in some instances even by intra-arterial blood transfusion.

"Ideally the management of the irreparably ruptured uterus, after the patient's condition warrants this procedure, is total hysterectomy. Even though it is known that leaving the cervix behind is not good treatment, it is justified in extreme situations. In the instance of broad ligament hematoma the cervix must be removed because of the possibility of rupture, not only of the lower uterine segment, but indeed the entire cervix and even the upper portion of the vagina. After the uterus has been totally removed it is advisable to explore the upper portion of the vagina for an extension of a laceration. This is also true in low lacerations of the posterior wall of the uterus."

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## Franklin County Pelvic Cancer Delay Committee Report

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee at its regular monthly meeting held on December 20, 1961.

**Case No. 98:** The patient is a 47 year old white woman, gravida II, Para II, who had a total abdominal hysterectomy and bilateral salpingo-oophorectomy in September for a diagnosis of uterine fibroids. During the past six months patient's main complaints have been uterine bleeding and increase in the size of her lower abdomen. Pathology report revealed uterine fibroids and adenocarcinoma of the cervix. After her discharge from the hospital on her seventh postoperative day, the patient was transferred to the Gynecology Tumor Clinic at Ohio State University Hospital for definitive irradiation therapy.

### Comments

This case represents a violation of one of the most important principles governing hysterectomy. A diagnostic dilatation and curettage should precede every hysterectomy particularly when hysterectomy is indicated in the older age group. A patient with uterine fibroids could very easily have co-existing cervical carcinoma, endometrial carcinoma, or uterine sarcoma. Ideal therapy for cervical carcinoma cannot be instituted if the uterus has been previously removed. This patient received less than ideal therapy for cervical carcinoma.

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## Pseudomonas Infections in Infants And Children

The incidence and severity of pseudomonas infections at Los Angeles Childrens Hospital increased from 1952 to 1957. These infections, as manifested by sepsis, meningitis, empyema and wound infections, have become progressively more difficult to control. Most serious pseudomonas infections have been associated with other debilitating illness necessitating extensive surgical and medical procedures with prolonged antibiotic administration. The young infant is most susceptible.

Useful antibiotics in order of effectiveness are polymyxin, oxytetracycline, tetracycline and streptomycin. Combined therapy using polymyxin with the tetracyclines or streptomycin is recommended. Local administration of polymyxin into closed cavities and topically is helpful in increasing the concentration of the drug at the site of the infection. — Lyal D. Asay, M. D., and Richard Koch, M. D., *The New England Journal of Medicine*, 262:1062-1066, May 26, 1960.

Special Article

# For Sale: Used and Abused Bodies

LINDEN F. EDWARDS, Ph. D.*

DURING the 1870's one of the chief purveyors of human cadavers to the medical schools in Cincinnati was a notorious character by the name of William Cunningham, better known locally as "Old Cunny."[1] According to one of the many stories told about him, he had sold his body to the Professor of Anatomy of the Medical College of Ohio for the sum of five dollars during a weak moment when he was sadly lacking in sufficient funds to supply his craving thirst for a bottle of whisky. Following his death his widow refused to release his remains to the Anatomy Professor until she received an additional five dollars in payment for her bereavement.

## Sale of One's Body Illegal

Regardless of the veracity of this story, apparently it was not uncommon in those days for a person to enter into negotiation for the sale of his body to a Professor or Demonstrator of Anatomy, whereby he collected his fee while still living thus enabling him to enjoy the benefits of the transaction, the consummation of which terminated upon his demise when his body was delivered to the purchaser. It is not known exactly when this practice ceased, although it became illegal with the passage of Anatomy Laws in the various states.[2] For some strange reason the rumor still persists in this state to the effect that medical colleges purchase bodies of individuals who are living and whose bodies are subject to delivery following their death. That such rumors persist is evident from the large number of letters of inquiries received at the Ohio State University College of Medicine.

## Numerous Letters of Inquiry Received

These letters may be classified into three categories: first, those in which the writer merely asks for information about the procedure to follow, and may or may not inquire as to the sum paid by the medical college for the body; second, those in which the writer furnishes a detailed account of his physical symptoms or ailments, ostensibly as a sales pitch in order to impress the would-be purchaser with the value of the diseased body to medical science; and third, those in which the writer frankly admits he is in dire need of the cash he may receive for his body and is using this means as a last resort.

Although a few of the letters received are well typed on standard 8½" x 11" typewriter bond paper most of them are more or less illegibly written in long hand on ruled stationery, either in pencil or ink. Judging from the poor spelling and sentence structure and oftentimes improper, or sheer lack of, punctuation many of the letters are written by poorly educated individuals. The envelopes are variously and sometimes weirdly addressed, so much so that it is remarkable many of them ever reach their destination. The fact that they do, attests to the efficiency of our postal service. As might be expected the salutations are quite variable, although most of them use one of the standard forms, either *Dear Sirs* or *To Whom it May Concern*. The vast majority of the letters received are from Ohio residents, however, among those presently on file is one from each of the following states, namely, California, Florida, Missouri and Virginia.

Illustrative of some of the addressed letters received may be cited the following: Ohio State Medical School, Ohio; Dean of Ohio State University, Columbus, Ohio; Ohio State University, Cleveland, Ohio; Director of Medical Science, Ohio State University, Columbus, Ohio; Medical Center, Columbus, Ohio; Director of Medical Department, Ohio State University; University Hospital, Route 23, Columbus, Ohio; and Ohio State University, Columbus, Ohio.

## Quotations of Some Letters Received

The following exact quotations of some of the letters received represent samples of the three categories mentioned above. Naturally, names and addresses of the writers are omitted.

"Dear friends, Some one told me about you give $1500.00 fore thire body this is after they die and you get the money is this true Right back and tell me something about it you can have mine for $1500.00 Hundred Dollars."

Believe it or not but even school kids are interested in such a transaction as judged from this letter:

"Dear Sirs: I am writing to you because, my teacher said that you buy people when they are alive and after they have died you use them for classes. Is this trure? If it is

*Dr. Edwards, Columbus, is Professor of Anatomy, The Ohio State University College of Medicine.

Submitted July 11, 1961.

true, I am hopping you will buy me . . . Please inform me about it."

Most of the inquiries about the sale of their bodies because of financial reasons frankly admitted by the writers sound strangely alike, the reason most commonly offered being the support of their young children. Needless to say the contents of some of these letters are really tear-jerkers and would touch the sympathy of the most hard-hearted anatomist. For example, one mother pathetically replied as follows to a letter of refusal to accept her offer to sell her body to the Department of Anatomy:

"I am writing you again in hopes I can gain some satisfaction from my efforts. Is it at all possible that the University would be interested in say an eye or any parts thereof of the body? I am of sound mind and know what I am doing. I am forty years old and I can assure you this is no whim, I am most serious. I was left three children to raise, ages 8-9 and 11 and feel that anything I can do to help them now and in the future would be very little asked of me. I do hope, I have not caused you any inconvenience or trouble as I realize how busy you must be. I anxiously will be awaiting an answer."

### Some Real Bargains Offered For Sale

Herewith are two samples of letters from persons who describe their ailments apparently with the thought in mind of offering the College of Medicine a real bargain for the sale of their bodies. The first one writes,

"Dear Sir: I have been talking to Some of our Doctor & specetists. about my condition. they want to operate on me It seem no use they tell me they cannot do me any good. I have Bad gall Bladder, Hemoroids Fistulas, Rectal absesses & other thing wrong also have psorasis I though I would sell my body to sience. for study. a nurse told me to write to you."

The second quotation is really a gem and was purposely saved till last as indicative of the irrational contents of some of the letters received. It is quoted almost verbatim.

"University Hospital. Dear Sir. On Sept. 24 of this year I started a medical check up at the Out Patient Department. But on Oct 15th of this year 19,59. it had to be dropped- Due to finance difficulty- in this medical check up I was told I have 4 plus sugar in my blood. I believe the Doctors Because if anything happens it happens to me- While in service 19.36. I was operated on for a swolen testical- just a short time later I began sufferin with my back.

"I cant hold a job no place I go. There is a chip on my shoulder. I cant get it off no matter how hard I try- I cant reason with my Foreman at all. That is out. I try thinking of my family my wife are one of our 5 children that dosent help a bit. I always end up fired are just stay home with my back and get fired.

"Gentlemen I may as well get to the point- And I want to Remind you this is no Crank letter- it may sound a little silly are some words mispelt. But Ive Never been more serious My 5 children is in the mountain Mission School being cared for -till I can give them a home. I placed them there at my own freewill—they wasent taken from me.

"Heres my proposition Id like to sell my Body to be used for experiment are any Purpose to benefit the human race if this the University Hospital isnt in the market for purchasing Bodys will you be so Cind as to run it in the Columbus dispatch ad column-

"On the day Im Deceased I will Sign Papers now giving medical Society full owner of my body. The price I ask is two hundred twenty five thousand dollars $2,25000 Thanking you Verry Cindly for your time and Patience. Im waiting an early reply Verry Cincerly."

### All Letters of Inquiry Answered

It should be emphasized that all letters received bearing upon the sale of one's body to the College of Medicine are answered. Invariably the reply is simply to the effect that according to the Laws of the State of Ohio it is illegal for an individual, institution or organization to purchase a human body regardless of whether it is dead or alive and whether or not it is used for scientific study.

It should also be emphasized that the objective aimed at in presenting this material is not to amuse the reader but rather to bring to light the fact that in these modern times a considerable number of human beings are willing to sell their bodies to a medical college. Some of them are honestly interested in making a contribution to Medical Science, while others are in desperate financial straits.

### Growing Interest in Bequeathal Of Bodies

As opposed to those individuals who for one reason or another are desirous of selling their bodies for cash is a growing number of people who have signed a codicil to their wills bequeathing their bodily remains following their death to one of the medical colleges in Ohio for teaching purposes, scientific research or such purposes as the authorized representatives of these colleges shall in their discretion deem advisable. Although the Ohio Courts do not recognize a person's right to will his own body, these medical colleges upon request will provide forms to anyone for him to fill out, by means of which he can indicate his desire to donate his body to one of these colleges. Included on these forms is a certificate for the signatures of his nearest relatives to signify their willingness to waive claim to the body of the donor after his death.

### Unsuccessful Attempt To Legalize Bequeathal of Bodies

During the 104th Session of the Ohio General Assembly Senator Donald C. Steiner, 21st District, Canton, Ohio, introduced S. B. 567, the purpose of which was to provide that *"a person of full age, sound mind and memory, and not under restraint may by a dated written instrument executed in the manner prescribed for the execution of wills in section 2107.03 of the Revised Code, make a gift of all or any part or parts of his body to a medical or educational institution within or without this state, such gift to take effect upon his death."* Unfortunately when this bill came up for vote on the floor of the Senate it failed to receive sufficient support for passage. Probably this was because the bill was introduced late in the session which did not allow adequate time for those in favor of the measure to build up sufficient sentiment in favor of the proposal.

In view of a growing acute shortage of human dis-

section material, due to increasing enrollments in educational institutions and to the availability of social welfare funds for burial, and, because of the growing desire of more and more of our citizens to make a gift legally of all or any part or parts of their bodies to educational institutions for teaching purposes, there is no doubt but that another effort will be made in a future session of the Ohio General Assembly to adopt some sort of a measure to provide for such gifts legally.

### Appeal for Popular Support of Future Assembly Bills

The question that arises in the minds of those people who are deeply concerned with their human rights to have their bodies disposed of as they see fit and with adequate training of our future physicians, nurses and dentists and other members of the health professions, is how to combat those forces that are apparently antagonistic to such objectives. The answer should be self-evident, namely, an overwhelming popular support of any future bill that provides for such a measure.

It is hoped that should another bill similar to the Steiner Bill be introduced at some future session of the Ohio General Assembly the measure will be presented early in the session in order to give those who aspire for the bill's objectives an opportunity to properly present arguments in favor of the measure to their legislators. Also, it is to be hoped that when that occasion arises, members of the health professions and others who recognize the value of such a law will become active in having the bill enacted.

### References

1. Edwards, Linden F.: Cincinnati's "Old Cunny," A Notorious Purvevor of Human Flesh. Ohio State Med. J., 50(5):466-468, May, 1954.

2. Edwards, Linden F.: The Ohio Anatomy Law of 1881, ibid., 46:1190-1192 (Dec.) 1950; 47:49-52 (Jan.) 1951; 47:143-146 (Feb.) 1951.

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ASTIGMATISM OF ARTISTS.—Abnormal vision is believed responsible for the distinctive art styles of three famous Renaissance artists, Holbein, Cranach and El Greco. The peculiarly distorted images that give their paintings their mark of greatness represented the world as they saw it.

"If Holbein, Cranach and El Greco had lived in the present time they undoubtedly would have been fitted with corrective glasses in childhood, leaving them perhaps with normal eyesight; but if such had been the case they would never have produced those strange and highly individual masterpieces that grace art galleries today."

Astigmatism was not investigated and aided until the latter part of the 19th century. In attempting to define the astigmatic defects of some Renaissance artists the author cites a study by Ahlstrom of the paintings of Leonardo da Vinci, Hans Holbein, Lucas Cranach and El Greco. There were great differences in these artists' ways of seeing things; only da Vinci had normal eyesight. Holbein portrayed his subjects as broad and robust. His portraits of Henry VIII display massive breadth of chest whereas his painting of Christ reclining depicts an "incredibly long slender" person. This justifies the conclusion that Holbein saw all objects as distended laterally.

In the portrait figures of Cranach an outstanding characteristic is the decided slenderness of most of the subjects. Thus it would appear that Cranach perceived objects as being thinner than they really were.

In some cases the refractive power may be stronger in some position other than the vertical or horizontal axis. El Greco appears to fall in this group. In many of his figures can be seen an uneasiness or nervousness or restless angle of posture; many appear to be leaning or gliding toward the right.

An experiment was conducted. Several observers with normal eyesight viewed the works of these masters through concave cylindrical lenses. Holbein's subjects acquired normal proportions when viewed through a lens placed at an axis of 90 degrees or vertical, correcting his tendency to see things as distended laterally. The work of Cranach took on normal proportions when the lens was placed at an axis of 180 degrees or horizontally. El Greco's figures became of normal dimensions when the same lens was held at an oblique axis of 15 degrees. — (ABSTRACT): W. G. Ridgeway: The Ocular Problems of Some Famous Men, *Missouri Medicine,* 58:1133 (November) 1961.

# Current Status of H.R. 4222; Ways To Defeat It Outlined

AS THIS ISSUE of *The Journal* went to press, the status of H. R. 4222, the Kennedy-King-Anderson bill to provide a system of government compulsory health insurance for Social Security beneficiaries and of the battle going on in Congress as a result of this proposal, was as follows:

**1.** H. R. 4222 still is in the hands of the House Ways and Means Committee which has shown no disposition as yet to report it to the floor for action . . . in fact, some believe favorable action by the committee is unlikely unless pressure by administration becomes intolerable.

**2.** Senator Anderson has threatened to propose text of H. R. 4222 as a rider to some bill passed by House and awaiting Senate action in order to force a vote in Senate on the principle of H. R. 4222. Senate Finance Committee chairmanned by Senator Byrd has refused to hold hearings on Anderson's version of H. R. 4222, believing House should act first. The prediction is that the vote, if any, could be very close in the Senate on this issue, perhaps only a few votes separating the pros and cons.

**3.** A compromise-proposal has bobbed up. Senator Javits, R-N. Y., has introduced S. 2664. It provides preventive, diagnostic and short-time, with limited medical, hospital and nursing home benefits; major medical on service basis; and indemnity type benefits. The financing would be from Social Security funds with states having option of handling administration or having HEW department do so. It would cover three-fourths of 17 million persons 65 and over.

### The Blue Shield Proposal

**4.** Plans for a uniform nationwide Blue Shield program for all persons 65 and over have been announced by the National Association of Blue Shield Plans. Having AMA endorsement, the plan envisions uniform premium, service benefits and income limits. It is proposed that it would be underwritten and administered by local Blue Shield plans. Details on this are scarce at this time.

How Ohio Medical Indemnity, Ohio's Blue Shield Plan, would fit into this picture is problematical as OMI is an indemnity plan. The officials of OMI have the matter under study. The plan would be entirely voluntary and would not require government subsidy.

A point of interest is the fact that in mid-1960 Ohio Medical Indemnity offered its preferred insurance coverage on a group basis to Ohioans 65 and over. Some 65,000 persons signed up for this medical and surgical coverage during an open-enrollment period. Also, some 40,000 additional Ohioans, who had OMI coverage on a group basis while employed, transferred to an individual pay-direct basis upon retirement and still are covered for medical-surgical costs. OMI officials are considering the possibility of another state-wide open enrollment. Also, they are planning to emphasize to all subscribers the opportunities afforded to retired persons to continue coverage on an individual basis.

### The Blue Cross Proposals

**5.** Additional details have not been made available about a proposed nationwide Blue Cross plan for those 65 and over which had been announced by the American Hospital Association and the National Association of Blue Cross Plans. (See February *OSMA Journal,* page 202 for story on this). That plan contemplates voluntary hospital costs insurance coverage for oldsters with government subsidy for those who can't afford to pay the costs of such insurance. Presumably the financing for the needy could come from Social Security funds. To-date, a "draft" bill to carry out this idea has not been announced.

### Ways To Beat H. R. 4222

**6.** National legislative conference of AMA in Chicago agreed that H. R. 4222 can be defeated or shelved if a national drive against it is launched. Also, it was agreed that the medical profession must mobilize the people and lead them in the attack.

Some of the methods proposed for accomplishing the foregoing are as follows: (1) Letters from the people to Congressmen; (2) speakers before lay groups; (3) newspaper advertising and radio and TV advertising and programs; (4) newspaper articles on talks by the opponents; (5) distribution of pamphlets and brochures; (6) films; (7) resolutions by hundreds of organizations and groups; (8) stressing the positive programs of voluntary insurance and the current public assistance medical-hospital programs for those 65 and over who need some help to meet their bills.

*Announcing . . .*

# The Official Program

for the

# 1962 ANNUAL MEETING

# Ohio State Medical Association

## COLUMBUS

MONDAY *thru* FRIDAY



MAY 14-18

On the following pages are details of Ohio's Number One Post-graduate Program for Physicians. On the next page are highlights of the meeting. The succeeding pages contain the day-by-day schedule of events. Consult these daily schedules for time and place of event; then, for details as to subjects, speakers, etc., turn to the chronological program beginning on page 332.

# Highlights of the Annual Meeting

**Time and Place:** Sessions of the **House of Delegates,** Monday evening, May 14 beginning with dinner, and Wednesday afternoon beginning at 3:00 p. m.; Resolutions Committees, Tuesday; all in the Neil House, Columbus. The **Scientific Sessions** begin Wednesday morning, May 16, at 9:30 a. m. and continue through Friday afternoon, in the Veterans Memorial Building and the Neil House, or as indicated in the program. A few specialty societies will continue their programs into Saturday. **Exhibits** open on Wednesday, May 16 at 9:00 a. m. and close on Friday at 3:30 p. m.

**Registration:** Headquarters for Registration will be in the West Entrance Lobby on the Ground Floor of the Veterans Memorial Building, 300 W. Broad Street, Columbus, open Wednesday, Thursday and Friday from 8:30 a. m. to 5:30 p. m. Special provisions will be made to register those attending the House of Delegates on Monday.

Those eligible to register are members of the Ohio State Medical Association (who should present 1962 Membership Cards at time of registration); physicians from other states who are members of their respective state medical associations; residents, interns and medical students; nurses, health workers and others who are presented as guests at Registration Headquarters by members. Letters of introduction on members' stationery also will be honored at Registration Headquarters. The Woman's Auxiliary will provide registration at the Deshler Hilton Hotel for its members and others who are eligible to attend Auxiliary sessions.

**Scientific Program:** Sessions begin at 9:30 a. m. on Wednesday, May 16 with a program by the Ohio State Heart Association. On Wednesday afternoon the Ohio Division, Inc., American Cancer Society, will present a program. On Thursday and Friday will be a variety of programs consisting of General Sessions, Specialty Section Programs, Specialty Society features, a special program sponsored by the Ohio State University College of Medicine faculty, and a special session on "What's New." On Thursday evening Fireside Conferences on Cardio-Respiratory Diseases will be sponsored in the Neil House by the OSMA and the Ohio Chapter of the American College of Chest Physicians.

**Scientific Exhibits:** This outstanding feature of the program will be in the Exhibit Hall on the Ground Floor of the Veterans Memorial Building, open from 9:00 a. m. to 5:30 p. m. on Wednesday and Thursday, May 16 and 17, and from 9:00 a. m. to 3:30 p. m. on Friday.

**Technical Exhibits:** Representatives of pharmaceutical and other supply houses will present exhibits of special interest to physicians on the Ground Floor of the Veterans Memorial Building, 9:00 a. m. to 5:30 p. m. on Wednesday and Thursday and from 9:00 a. m. to 3:30 p. m. on Friday.

**President's Ball:** This main social event of the Annual Meeting will be on Wednesday evening, May 16, beginning with cocktails at 6:30 p. m., then a buffet dinner, followed by entertainment and dancing — all included in the cost of tickets. A Dutch treat bar will be available during the period of social dancing. Make reservations early by securing your tickets in advance.

**The Woman's Auxiliary:** The ladies as usual will hold their annual meeting concurrently with that of the OSMA. Auxiliary sessions will be in the Deshler Hilton Hotel.

**House of Delegates:** The policy making and legislative body of the Association will meet twice during the Annual Meeting. First session will begin with dinner on Monday, May 14, in the Neil House; House Resolutions Committees will meet on Tuesday, and the final session of the House will be on Wednesday beginning at 3:00 p. m.

**Specialty Societies:** A number of Specialty Societies are cooperating with the OSMA in the Annual Meeting program (See page 342 for their special features in the program and for announcements of luncheons, dinners and other events).

# SCHEDULE OF EVENTS

## MONDAY, MAY 14

### NEIL HOUSE
### COLUMBUS

(Time Shown—Eastern Standard Time)

| TIME | EVENT | PLACE |
|---|---|---|
| 6:00 P. M. | **HOUSE OF DELEGATES COMPLIMENTARY DINNER FOR DELEGATES, ALTERNATES, OFFICERS AND COUNCILORS, TO BE FOLLOWED BY BUSINESS SESSION** (See Wednesday schedule for second session of House of Delegates) | Grand Ballroom Mezzanine Floor Neil House |

# SCHEDULE OF EVENTS

## TUESDAY, MAY 15

### NEIL HOUSE
### COLUMBUS

(Time Shown—Eastern Standard Time)

| TIME | EVENT | PLACE |
|---|---|---|
| 9:00 A. M. | **MEETINGS OF HOUSE OF DELEGATES REFERENCE COMMITTEES ON RESOLUTIONS** (See Wednesday schedule for second session of House of Delegates) | Parlors 1, 4 and B Mezzanine Floor Neil House |

## Survival Car II on Display

The Ohio State Medical Association's Committee on Traffic Safety is exhibiting at the 1962 Annual Meeting, Survival Car II, an especially-built automobile incorporating 24 safety features designed to "package" the passengers for prevention or amelioration of injury in accidents.

Constructed by the Liberty Mutual Insurance Company, the car features such innovations as "capsule" chairs with seat belts and shoulder harness to prevent whiplash injury, flexible steering shaft and telescoping steering shaft housing, automatic fire control system, roll-over bar, and many others.

The car designed to permit passengers to walk away from head-on collisions which may occur at speeds up to 40 miles per hour, will be on display in the Exhibit Hall, ground floor, Veterans Memorial Building.

# SCHEDULE OF EVENTS

## WEDNESDAY, MAY 16

**All sessions at the Veterans Memorial Building, 300 West Broad St., unless otherwise indicated**

(Time Shown—Eastern Standard Time)

| TIME | EVENT | PLACE |
|---|---|---|
| 8:30 A. M. | **REGISTRATION OPENS** | West Entrance Lobby, Exhibit Hall Ground Floor |
| 9:00 A. M. | **OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS** | Exhibition Hall Ground Floor |
| 9:30 A. M. | **GENERAL SESSION** (Program presented by the Ohio State Heart Association) | Assembly Hall Veterans Wing, First Floor |
| 9:30 to 10:30 A. M. | Rudolph Allen Gerlinger Memorial Lecture "Changing Concepts of Pericarditis: Acute and Chronic" | Assembly Hall Veterans Wing, First Floor |
| 10:30 to 11:00 A. M. | **RECESS FOR TOUR OF EXHIBITS** | |
| 11:00 A. M. to 12:30 P. M. | "Diagnosis and Management of Pericardial Disease" (Panel Discussion) | Assembly Hall Veterans Wing, First Floor |
| 2:00 P. M. | **GENERAL SESSION** (Program presented by the Ohio Division, Inc., American Cancer Society | Assembly Hall Veterans Wing, First Floor |
| 2:00 to 2:15 P. M. | **ADDRESSES OF WELCOME** | Assembly Hall Veterans Wing, First Floor |
| 2:15 to 3:00 P. M. | "The Conservative vs. the Radical Approach to Cancer of the Breast" | Assembly Hall Veterans Wing, First Floor |
| 3:00 to 3:30 P. M. | Tour of Exhibits and Coffee Break | |
| 3:00 P. M. | **HOUSE OF DELEGATES FINAL BUSINESS SESSION** | Neil House Grand Ballroom Mezzanine Floor |
| 3:30 to 5:00 P. M. | **CONTINUATION OF GENERAL SESSION PROGRAM** "Practical Problems in the Management of Cancer" (Panel Discussion) | Assembly Hall Veterans Wing, First Floor |
| 6:30 P. M. | **THE PRESIDENT'S BALL** Cocktails—Buffet Dinner—Entertainment—Dancing | Neil House Mezzanine Lounge and Grand and Junior Ballrooms |

# SCHEDULE OF EVENTS

## THURSDAY, MAY 17

**All sessions at the Veterans Memorial Building, 300 West Broad St., unless otherwise indicated.**

(Time Shown—Eastern Standard Time)

| TIME | EVENT | PLACE |
|---|---|---|
| 8:30 A. M. | **REGISTRATION** | West Entrance Lobby, Exhibit Hall Ground Floor |
| 9:00 to 9:30 A. M. | **TOUR OF EXHIBITS** | Exhibition Hall Ground Floor |
| 9:30 to 10:30 A. M. | **OHIO PSYCHIATRIC ASSOCIATION** | Room G-20 (South Terrace) Exhibit Floor |
| 9:30 A. M. | **OSMA GENERAL SESSION** (Program by Faculty, Ohio State University College of Medicine) | Assembly Hall Veterans Wing, First Floor |
| 9:30 to 10:30 A. M. | "Backache" (Symposium) | Assembly Hall Veterans Wing, First Floor |
| 10:30 to 11:00 A. M. | **RECESS FOR TOUR OF EXHIBITS** | Exhibition Hall Ground Floor |
| 11:00 A. M. to 12:00 Noon | **OSMA GENERAL SESSION** "Virus Diseases—1962" (Panel Discussion) | Assembly Hall Veterans Wing, First Floor |
| 11:00 A. M. to 12:00 Noon | **CONTINUATION OF MEETING OF OHIO PSYCHIATRIC ASSOCIATION** | Room G-20 (South Terrace) Exhibit Floor |
| 12:00 Noon | **OHIO PSYCHIATRIC ASSOCIATION** Luncheon | (Place to be announced) |
| 12:30 P. M. | **OHIO NEUROSURGICAL SOCIETY** Luncheon | Columbus Athletic Club |
| 2:00 to 3:00 P. M. | **INTERNAL MEDICINE** (Program by Section on Internal Medicine and Ohio Society of Internal Medicine.) | Assembly Hall Veterans Wing, First Floor |
| 2:00 to 3:00 P. M. | **NERVOUS AND MENTAL DISEASES** (Program by Section on Nervous and Mental Diseases and Ohio Psychiatric Association.) | Room G-20 (South Terrace) Exhibit Floor |
| 2:00 to 3:00 P. M. | **NEUROLOGICAL SURGERY** (Program by Section on Neurological Surgery and Ohio Neurosurgical Society.) | Room 205 Veterans Wing, Second Floor |

*(Continued On Next Page)*

# SCHEDULE OF EVENTS

## THURSDAY, MAY 17

**All sessions at the Veterans Memorial Building, 300 West Broad St., unless otherwise indicated**

**(Time Shown—Eastern Standard Time)**

*(Thursday's Schedule Continued)*

| TIME | EVENT | PLACE |
|---|---|---|
| 2:00 to 3:00 P. M. | **OBSTETRICS AND GYNECOLOGY**<br>(Program by Section on Obstetrics and Gynecology) | Room 201<br>Veterans Wing, Second Floor |
| 2:00 to 3:00 P. M. | **OPHTHALMOLOGY**<br>(Program by Section on Ophthalmology and Ohio Ophthalmological Society) | Rooms 203-204<br>Veterans Wing, Second Floor |
| 2:00 to 3:00 P. M. | **OTORHINOLARYNGOLOGY**<br>(Program by Section on Otorhinolaryngology) | Rooms 206-207<br>Veterans Wing, Second Floor |
| 2:00 to 3:00 P. M. | **CONFERENCE ON LABORATORY MEDICINE**<br>(Program by OSMA Committee on Laboratory Medicine) | Lower Mezzanine Lounge |
| 3:00 to 3:30 P. M. | **RECESS FOR TOUR OF EXHIBITS** | Exhibition Hall<br>Ground Floor |
| 3:30 to 5:00 P. M. | **CONTINUATION OF SPECIALTY MEETINGS** | |
| 3:30 to 5:00 P. M. | **OHIO CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS** | Room 202<br>Veterans Wing, Second Floor |
| 5:30 to 8:00 P. M. | **OHIO CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS**<br>Cocktails, Dinner, Scientific Program | Neil House<br>Junior Ballroom, Mezzanine Floor |
| 6:00 P. M. | **OHIO SOCIETY OF INTERNAL MEDICINE**<br>Cocktails and Dinner | Deshler Hilton Hotel |
| 6:30 P. M. | **OHIO NEUROSURGICAL SOCIETY**<br>Cocktails and Dinner | Kahiki Restaurant |
| 8:00 P. M. | **FIRESIDE CONFERENCES ON CARDIO-RESPIRATORY DISEASES**<br>(Sponsored jointly by the Ohio Chapter, American College of Chest Physicians and Ohio State Medical Association) | Neil House<br>Grand Ballroom, Mezzanine Floor |

# SCHEDULE OF EVENTS

## FRIDAY, MAY 18

**All sessions at the Veterans Memorial Building, 300 West Broad St., unless otherwise indicated**

**(Time Shown—Eastern Standard Time)**

| TIME | EVENT | PLACE |
|---|---|---|
| 8:30 A. M. | **REGISTRATION** | West Entrance Lobby, Exhibit Hall Ground Floor |
| 9:00 to 9:30 A. M. | **TOUR OF EXHIBITS** | Exhibition Hall Ground Floor |
| 9:30 to 10:30 A. M. | **GENERAL SESSION**<br>"What's New?"<br>In Long-Term Anticoagulant Therapy<br>In Use of Vaccines<br>In Enzymes in Diagnosis<br>In Oral Antiovulatory Agents<br>In Antibiotic Prophylaxis | Assembly Hall Veterans Wing, First Floor |
| 10:30 to 11:00 A. M. | **RECESS FOR TOUR OF EXHIBITS** | Exhibition Hall Ground Floor |
| 11:00 to 11:30 A. M. | **GENERAL SESSION**<br>"Some Important Aspects of the Newer Drugs" | Assembly Hall Veterans Wing, First Floor |
| 11:30 A. M. to 12:00 Noon | **GENERAL SESSION**<br>"Radiation Hazards" | Assembly Hall Veterans Wing, First Floor |
| 1:30 to 3:00 P. M. | **PATHOLOGY**<br>(Program by Section on Pathology and the Ohio Society of Pathologists) | Room G-20 (South Terrace) Exhibit Floor |
| 2:00 to 3:00 P. M. | **ANESTHESIOLOGY**<br>(Program by Section on Anesthesiology) | Rooms 206-207 Veterans Wing, Second Floor |
| 2:00 to 3:00 P. M. | **GENERAL PRACTICE**<br>**OCCUPATIONAL MEDICINE**<br>**PHYSICAL MEDICINE**<br>**RADIOLOGY**<br>(Program by Sections on General Practice of Medicine, Physical Medicine, and Radiology and the Ohio Society of Physical Medicine and Rehabilitation) | Assembly Hall Veterans Wing, First Floor |
| 2:00 to 3:00 P. M. | **ORTHOPAEDIC SURGERY**<br>(Program by Section on Orthopaedic Surgery and the Ohio Orthopaedic Society) | Rooms 203-204 Veterans Wing, Second Floor |
| 2:00 to 3:00 P. M. | **PEDIATRICS**<br>(Program by Section on Pediatrics and the Ohio Chapter, American Academy of Pediatrics) | Room 201 Veterans Wing, Second Floor |

*(Continued On Next Page)*

# SCHEDULE OF EVENTS

## FRIDAY, MAY 18

**All sessions at the Veterans Memorial Building, 300 West Broad St., unless otherwise indicated**

*(Friday's Schedule Continued)*

| TIME | EVENT | PLACE |
|---|---|---|
| 3:00 to 3:30 P. M. | **RECESS FOR TOUR OF EXHIBITS** | Exhibition Hall<br>Ground Floor |
| 3:00 to 5:00 P. M. | **CONTINUATION OF SPECIALTY MEETINGS** | |
| 5:30 P. M. | **OHIO SOCIETY OF PATHOLOGISTS AND SECTION ON PATHOLOGY**<br>Business Meeting, Social Hour, Dinner | The Maramor |
| 7:00 P. M. | **OHIO SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION**<br>Cocktails and Dinner | Olentangy Inn |

# Art Exhibit Planned for OSMA Annual Meeting in Columbus

A Physicians Art Exhibit will be a feature of the OSMA Annual Meeting in Columbus, May 14 - 18, and applications for space will be reviewed by a committee headed by Dr. Thomas E. Newell, Dayton. Physicians who have paintings or other pieces of art are invited to fill out the following application form and mail it to The Ohio State Medical Association, 79 E. State St., Columbus 15, Ohio:

**Application for Space in Physicians Art Exhibit**

Name:.....Address:.....

City:.....

Type and number of pieces to be displayed: Painting.....Photography.....

Sculpture.....Crafts:.....other.....

Estimated amount of space required in lineal feet or square feet:.....

.....

General information, if any:.....

.....

.....

# DELEGATES AND ALTERNATES

| Counties | Delegates | Alternates |
|---|---|---|
| **FIRST DISTRICT** | | |
| ADAMS | Robert B. Ellison | Stanley H. Title |
| BROWN | | |
| BUTLER | John A. Carter | Dane Barber |
| | Paul N. Ivins | Louis B. Gaker |
| CLERMONT | Charles M. Simmons | Donald K. Ebersold |
| CLINTON | Edmond K. Yantes | Richard R. Buchanan |
| HAMILTON | Frank P. Cleveland | Robert L. Coith |
| | Joseph G. Crotty | Sanford R. Courter |
| | Neal N. Earley | Robert S. Heidt |
| | Douglas P. Graf | Thomas Jenike |
| | David L. Graller | Howard F. C. Pfister |
| | Harry K. Hines | James D. Phinney |
| | J. Robert Hudson | Joseph J. Podesta |
| | Daniel V. Jones | H. Willis Ratledge |
| | William A. Moore | Richard T. F. Schmidt |
| | Clyde S. Roof | Garfield L. Suder |
| | Charles A. Sebastian | Samuel P. Todd, Jr. |
| | I. C. Sharon | Calvin F. Warner |
| HIGHLAND | J. Martin Byers | Clifford G. Foor |
| WARREN | R. E. Simendinger | D. Paul Ward |
| **SECOND DISTRICT** | | |
| CHAMPAIGN | Isador Miller | Victor R. Frederick |
| CLARK | Robert A. McLemore | G. P. Fitzgerald, Jr. |
| | J. Harold Shanklin | John F. Harley |
| DARKE | Maurice M. Kane | Charles E. Gariety |
| GREENE | Roger C. Henderson | C. G. McPherson |
| MIAMI | David M. Spencer | John W. Gallagher |
| MONTGOMERY | Kenneth D. Arn | William H. Fries |
| | Robert A. Bruce | Marion V. Lingle |
| | Theodore L. Light | Wm. M. Porter |
| | James G. Tye | James W. Priest |
| | Sylvan L. Weinberg | J. Richard Strawsburg |
| PREBLE | Chester J. Brian | |
| SHELBY | George Schroer | J. W. Tirey |
| **THIRD DISTRICT** | | |
| ALLEN | Dwight L. Becker | John W. Burke |
| | Fred P. Berlin | J. W. Zulliger |
| AUGLAIZE | Elizabeth Y. Kuffner | Clyde W. Berry |
| CRAWFORD | Martin M. Horowitz | Darrel D. Bibler |
| HANCOCK | Donald R. Brumley | |
| HARDIN | Wendell I. Zaring | William D. DeWar |
| LOGAN | Hobart L. Mikesell | Douglas W. Beach |
| MARION | Frederick T. Merchant | John T. Boxwell |
| MERCER | Donald R. Fox | George H. McIllroy |
| SENECA | | |
| VAN WERT | Edwin W. Burnes | Edward E. White |
| WYANDOT | Richard L. Garster | John M. Thompson |
| **FOURTH DISTRICT** | | |
| DEFIANCE | Francis M. Lenhart | William S. Busteed |
| FULTON | Benjamin H. Reed, Jr. | Clarence F. Murbach |
| HENRY | Thomas F. Tabler | Edwin C. Winzeler |
| LUCAS | E. F. Glow | W. A. Blank |
| | W. G. Henry | C. L. Felker |
| | E. F. Ockuly | J. B. Sawyer |
| | F. P. Osgood | H. E. Smith |
| | Frank F. A. Rawling | Merl B. Smith |
| | M. T. Schnitker | Robert P. Ulrich |
| OTTAWA | George A. Boon | Cyrus R. Wood |
| PAULDING | D. E. Farling | K. A. Pritchard |
| PUTNAM | | |
| SANDUSKY | | |
| WILLIAMS | Robert W. Dilworth | Edward M. Schneider |
| WOOD | Paul F. Orr | Frank V. Boyle |
| **FIFTH DISTRICT** | | |
| ASHTABULA | S. A. Burroughs | Samuel L. Altier |
| CUYAHOGA | Joseph C. Avellone | Wendell W. Adams |
| | James O. Barr | Frank M. Barry |
| | Joseph L. Bilton | Simon S. Bunin |
| | William F. Boukalik | Samuel E. Burkhart |
| | John H. Budd | C. A. Colombi |
| | E. Peter Coppedge | E. H. Crawfis |
| | Russell B. Crawford | Nicholas G. DePiero |
| | Eugene A. Ferreri | Robert H. Ebert |
| | William E. Forsythe | Harry A. Haller |
| | S. M. Goldhamer | John R. Haserick |
| | John J. Grady | Henry L. Hoffman |
| | Charles L. Hudson | John A. Hudec |
| | Chester R. Jablonoski | Vincent T. LaMaida |
| | Fred R. Kelly | Charles B. Lewis |
| | M. H. Lambright, Jr. | L. Philip Longley |
| | Charles L. Leedham | John D. Osmond, Jr. |
| | L. A. McCormack | Myron L. Pardee |
| | Paul A. Mielcarek | Charles J. Prochaska |
| | Russell P. Rizzo | J. M. Rossen |
| | P. John Robechek | John H. Sanders |
| | A. B. Schneider, Jr. | Leo H. Simoson |
| | | William Sinclair, Jr. |
| | | E. C. Weckesser |
| | | Sidney E. Wolpaw |
| GEAUGA | Alton W. Behm | Kayoshi Masuoka |
| LAKE | Benjamin S. Park | James G. Powell |

| Counties | Delegates | Alternates |
|---|---|---|
| **SIXTH DISTRICT** | | |
| COLUMBIANA | John A. Fraser | J. W. Schoolnic |
| MAHONING | G. E. DeCicco | Robert R. Fisher |
| | Paul J. Mahar | Frank Gelbman |
| | John J. McDonough | Harlan P. McGregor |
| | Asher Randell | Craig C. Wales |
| PORTAGE | Edward A. Webb | Myron W. Thomas |
| STARK | Maurice F. Lieber | A. R. Furnas, Jr. |
| | R. K. Ramsayer | Robert Graham |
| | C. V. Smith | M. L. Greenberger |
| | W. A. White, Jr. | G. D. Underwood |
| SUMMIT | Jess F. Bond | H. T. Baumgardner |
| | Walter A. Hoyt, Jr. | E. A. Riemenschneider |
| | James H. Pollock | James G. Roberts |
| | Leonard V. Phillips | Francis J. Waickman |
| | Paul L. Weygandt | |
| TRUMBULL | Raymond Ralston | James W. Loney |
| | E. R. Westbrook | Joseph A. Ralston |
| **SEVENTH DISTRICT** | | |
| BELMONT | F. W. Cook | R. H. McCommon |
| CARROLL | Joseph D. Stires | Carl A. Lincke |
| COSHOCTON | Norman L. Wright | Milton A. Boyd |
| HARRISON | Elias Freeman | George E. Henderson |
| JEFFERSON | Stanley L. Burkhardt | M. H. Rosenblum |
| MONROE | Byron Gillespie | |
| TUSCARAWAS | R. E. Rinderknecht | William E. Hudson |
| **EIGHTH DISTRICT** | | |
| ATHENS | Wm. H. Allen, Jr. | Ruth Matthewson |
| FAIRFIELD | Jack L. Kraker | Chester P. Swett |
| GUERNSEY | James A. L. Toland | Robert A. Ringer |
| LICKING | J. R. Wells | Warren N. Koontz |
| MORGAN | Henry Bachman | A. H. Whitacre |
| MUSKINGUM | Earl R. Haynes | Joseph C. Greene |
| NOBLE | Edward G. Ditch | Frederick M. Cox |
| PERRY | Alton J. Ball | Charles E. Bope |
| WASHINGTON | Ford E. Eddy | Kenneth E. Bennett |
| **NINTH DISTRICT** | | |
| GALLIA | Oscar W. Clarke | W. Lewis Brown |
| HOCKING | Owen F. Yaw | John W. Doering |
| JACKSON | | |
| LAWRENCE | George N. Spears | Harry Nenni |
| MEIGS | Roger P. Daniels | Edmund Butrimas |
| PIKE | Robert T. Leever | A. M. Shrader |
| SCIOTO | J. R. Sheets | Louis R. Chaboudy |
| VINTON | Richard E. Bullock | David Caul |
| **TENTH DISTRICT** | | |
| DELAWARE | A. R. Callander | Mary K. Kuhn |
| FAYETTE | | |
| FRANKLIN | Drew J. Arnold | E. T. Boles, Jr. |
| | William F. Bradley | Wiley L. Forman |
| | William H. Carter | Joseph C. Forrester |
| | Mel A. Davis | Edwin B. Hamilton |
| | Richard L. Fulton | Oscar W. Jepsen |
| | Thomas M. Hughes | William F. Lovebury |
| | Charles W. Pavey | T. A. Makley, Jr. |
| | Allen D. Puppel | Alexander Pollack |
| KNOX | James C. McLarnan | Henry T. Lapp |
| MADISON | Sol Maggied | John C. Starr |
| MORROW | Joseph P. Ingmire | Francis W. Kubbs |
| PICKAWAY | J. M. Hedges | E. L. Montgomery |
| ROSS | Robert E. Swank | Lewis W. Coppel |
| UNION | E. J. Marsh | Fred C. Callaway |
| **ELEVENTH DISTRICT** | | |
| ASHLAND | Myrle D. Shilling | Wayne C. Smith |
| ERIE | E. J. Meckstroth | R. H. Williamson |
| HOLMES | N. P. Stauffer | A. J. Earney |
| HURON | Owen J. Nicholson | Harold A. Erlenbach |
| LORAIN | John W. Newman | John Halley |
| | James T. Stephens | D. E. Harrison |
| MEDINA | Richard W. Avery | William G. Halley |
| RICHLAND | James O. Ludwig | Charles F. Curtiss |
| | William R. Roasberry | Riley E. Frush |
| WAYNE | Albert B. Huff | John M. Robinson |

## OFFICERS

| | | | |
|---|---|---|---|
| Pres. | George W. Petznick | Treas. | Philip B. Hardymon |
| Pres.-Elect | Geo. J. Hamwi | Past-Pres. | Edwin H. Artman |

## COUNCILORS

| District | | District | |
|---|---|---|---|
| First | Charles W. Hoyt | Seventh | B. C. Diefenbach |
| Second | Ray M. Turner | Eighth | Robert C. Beardsley |
| Third | Floyd M. Elliott | Ninth | Chester H. Allen |
| Fourth | Edwin R. Murbach | Tenth | Robert M. Inglis |
| Fifth | Henry A. Crawford | Eleventh, | Lawrence C. Meredith |
| Sixth | R. E. Tschantz | | |

## MONDAY, MAY 14

6:00 P. M. (E.S.T.)

### HOUSE OF DELEGATES COMPLIMENTARY DINNER FOR DELEGATES, ALTERNATES, OFFICERS AND COUNCILORS, TO BE FOLLOWED BY BUSINESS SESSION

Grand Ballroom, Mezzanine Floor
Neil House

Invocation.

Welcome by Richard L. Fulton, M. D., Columbus, President of the Columbus Academy of Medicine.

Introduction of the President, George W. Petznick, M. D., Cleveland.

Roll Call of Delegates.

Consideration of the minutes of the last Annual Meeting (June, 1961, issue of *The Journal*).

Introduction of honored guests.

Report by the President of the Woman's Auxiliary —Mrs. Lester W. Sontag, Yellow Springs.

Appointment of Reference Committees by the President:

Credentials.

President's Address.

Resolutions.

Tellers and Judges of Election.

Nomination and election of Committee on Nominations: (Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the Second Session, Wednesday, 3:00 P. M., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws.)

Introduction of Resolutions:

(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Wednesday afternoon session before any action can be taken. All resolutions must be typewritten and submitted in triplicate.)

Announcements of meeting places of Committee on Nominations and Reference Committees by chairmen of the committees.

Miscellaneous business.

Announcements of Annual Meeting events.

Recess.

## TUESDAY, MAY 15

9:00 A. M. (E.S.T.)

Parlors 1, 4 and B, Mezzanine Floor
Neil House

Meetings of House of Delegates Reference Committees on Resolutions. Any member of the Association is privileged to attend these meetings.

## WEDNESDAY, MAY 16

8:30 A. M. (E.S.T.)

### REGISTRATION OPENS

West Entrance Lobby, Exhibit Hall, Ground Floor
Veterans Memorial Building

9:00 A. M. (E.S.T.)

### OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS

Exhibition Hall, Ground Floor
Veterans Memorial Building

## WEDNESDAY, MAY 16

9:30 A. M. (E.S.T.)

### GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

Program presented by the Ohio State Heart Association.

### THE PARTICIPANTS

Howard B. Burchell, M. D., Rochester, Minn., Professor of Medicine, Mayo Clinic and Foundation.

Sanford R. Courter, M. D., Cincinnati, Assistant Professor of Medicine, University of Cincinnati College of Medicine.

Elmer R. Maurer, M. D., Cincinnati, Associate Clinical Professor of Surgery, University of Cincinnati College of Medicine.

William Molnar, M. D., Columbus, Professor of Radiology, Ohio State University College of Medicine.

Maurice A. Schnitker, M. D., Toledo, Past-President, Ohio State and Northwestern Ohio Heart Associations.

Richard N. Westcott, M. D., Cleveland, Department of Cardiovascular Diseases, Cleveland Clinic.

Presiding: Dr. Courter.

9:30 Rudolph Allen Gerlinger Memorial Lecture —Changing Concepts of Pericarditis: Acute and Chronic—Dr. Burchell.
(Introduction of speaker by Dr. Schnitker.)

10:30 Recess for Tour of Exhibits.

11:00 Diagnosis and Management of Pericardial Disease (Panel Discussion)

Moderator: Dr. Courter.

Members of Panel: Drs. Burchell, Maurer, Molnar and Westcott.

12:30 Adjournment.

## WEDNESDAY, MAY 16

2:00 P. M. (E.S.T.)

### GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

Program presented by the Ohio Division, Inc.
American Cancer Society.

### THE PARTICIPANTS

Frank Batley, M. D., Syracuse, N. Y., Associate Professor of Radiology, Upstate University of New York.

Joseph A. Bonta, M. D., Columbus, Clinical Assistant Professor of Surgery, Ohio State University College of Medicine.

George Crile, Jr., M. D., Cleveland, Head, Department of General Surgery, Cleveland Clinic Foundation.

William J. Flynn, M. D., Youngstown, President, Ohio Division, Inc., American Cancer Society.

George J. Hamwi, M. D., Columbus, President-Elect, Ohio State Medical Association.

Calvin T. Klopp, M. D., Washington, D. C., Warwick Professor of Surgery (Cancer), George Washington University School of Medicine.

John G. Masterson, M. D., Brooklyn, N. Y., Associate Professor of Obstetrics and Gynecology, Medical College State University of New York in Brooklyn.

George E. Moore, M. D., Buffalo, N. Y., Director, Roswell Park Memorial Institute.

Jerome A. Urban, M. D., New York, Associate Attending Surgeon, Memorial Sloan-Kettering Cancer Center.

Robert L. Wall, M. D., Columbus, Associate Professor of Medicine, Ohio State University College of Medicine.

Presiding: Dr. Bonta.

2:00 Addresses of Welcome—Drs. Flynn and Hamwi.

2:15 The Conservative vs. the Radical Approach to Cancer of the Breast—Drs. Urban and Crile.

3:00 Tour of Exhibits and Coffee Break.

3:30 Practical Problems in the Management of Cancer (Panel Discussion)

Moderator: Dr. Moore.

Members of Panel: Drs. Batley, Klopp, Masterson and Wall.

5:00 Adjournment.

## Guest Participants



Howard B. Burchell, M. D.
Rochester, Minn.



Frank Batley, M. D.
Syracuse, N. Y.



Calvin T. Klopp, M. D.
Washington, D. C.



George E. Moore, M. D.
Buffalo, N. Y.



Jerome A. Urban, M. D.
New York, N. Y.

All members of the Association are welcome to attend sessions of the House of Delegates as observers. Participation is limited to those who attend in an official capacity, as are the dinners preceding each session of the House. Members may attend and participate in the deliberations of the Reference Committees.

**WEDNESDAY, MAY 16**

3:00 P. M. (E.S.T.)

**HOUSE OF DELEGATES**

**FINAL BUSINESS SESSION**

Grand Ballroom, Mezzanine Floor
Neil House

Roll Call of Delegates.

Introduction of honored guests.

Consideration of unfinished business.

Reports of Reference Committees.

President's Address.

Resolutions.

Election of President-Elect. Nominations from the floor.

Report of Committee on Nominations:

(a) Nominations for The Council.
(Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years.)

To be elected:

**First District** — (Incumbent, Charles W. Hoyt, M. D., Cincinnati.)

**Third District**—(Incumbent, Floyd M. Elliot, M. D., Ada.)

**Fifth District**—(Incumbent, Henry A. Crawford, M. D., Cleveland.)

**Seventh District**—(Incumbent, B. C. Diefenbach, M. D., Martins Ferry.)

**Ninth District** — (Incumbent, Chester H. Allen, M. D., Portsmouth.)

**Eleventh District** — (Incumbent, Lawrence C. Meredith, M. D., Elyria.)

(b) Election of Delegates and Alternates to the American Medical Association—four Delegates and four Alternates to be elected, each for a two-year term starting January 1, 1963, in compliance with the Constitution and Bylaws of the American Medical Association.

The following incumbent Delegates and Alternates will serve for the remainder of 1962, and they may be considered by the nominating committee for re-election for two-year terms starting January 1, 1963:

Charles L. Hudson, M. D., Cleveland
(Delegate)

H. T. Pease, M. D., Wadsworth
(Alternate)

Carl A. Lincke, M. D., Carrollton
(Delegate)

Robert S. Martin, M. D., Zanesville
(Alternate)

*(Continued in Next Column)*

George A. Woodhouse, M. D., Pleasant Hill
(Delegate)

T. L. Light, M. D., Dayton
(Alternate)

Edmond K. Yantes, M. D., Wilmington
(Delegate)

Fred W. Dixon, M. D., Cleveland
(Alternate)

Installation of officers for 1962-1963.

Submission of committee appointments by the new President for confirmation by the House of Delegates.

Unfinished or new business.

Adjournment.

**WEDNESDAY, MAY 16**

6:30 P. M. (E.S.T.)

**THE PRESIDENT'S BALL**

Mezzanine Lounge, Junior and Grand Ballrooms, Mezzanine Floor
Neil House

Cocktails.

Buffet Dinner.

Introduction of Officers and Councilors.

Introduction of Distinguished Guests.

Program by the Buckeye Chapter, Society for the Preservation and Encouragement of Barber Shop Quartet Singing in America.

Dancing.

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## Jefferson Medical Alumni Reunion Scheduled Thursday, May 17

A get-together has been planned for alumni of Jefferson Medical College, their wives and guests who will attend the 1962 Annual Meeting of the Ohio State Medical Association, in Columbus, May 14-18. This will be the 11th annual dinner meeting of the group, replacing the one scheduled for April 11, 1961 in Cincinnati which was cancelled because of fire destruction of the Town and Country Restaurant.

This year the meeting will be held on Thursday, May 17, at the University Club, 40 South Third Street. Activities will begin with a "fellowship hour" at 6 o'clock, followed by dinner at 7:30, and "brief speeches" about "Jeff" at 8:30 P. M.

Alumni are urged to attend any portion of the program that adapts to their schedule. However, those who plan to attend dinner are requested to secure reservations in advance if possible through: Dr. "Jim" Ruppersberg, '33, 336 East State Street, Columbus 15. Tickets may be purchased at the door on Thursday, May 17.



# PRESIDENT'S BALL

## Wednesday, May 16, starting at 6:30 p. m.
## Neil House

***This traditional social highlight of the Annual Meeting will be patterned after last year's successful event.***

OSMA Members, their Wives and Friends are cordially invited to gather in the Junior Ballroom of the Neil House at 6:30 p. m. for cocktails, after which they will adjourn to the Grand Ballroom for a Buffet Dinner Dance, followed by entertainment and an evening of dancing.



Special Entertainment Feature: Here is the opportunity to see and hear SPEBSQSA — the Society for the Preservation and Encouragement of Barber Shop Quartet Singing in America — in action. Actually you will hear the Buckeye Chorus of 50 voices with special selections by one or two quartets. This is one of the top-flight choruses in the nation.

Your ticket entitles you to cocktails, dinner, special entertainment, and the evening of dancing, and includes tips. A Dutch treat bar will be available during the period of social dancing.



**You can order your PRESIDENT'S BALL TICKETS on this coupon**

**ORDER FOR TICKETS FOR OHIO STATE MEDICAL ASSOCIATION PRESIDENT'S BALL**

*Neil House, Columbus . . . . . May 16, 6:30 p. m.*

Send me.....tickets at a cost of $12.50 each for the President's Ball, Ohio State Medical Association Annual Meeting, Columbus. Price covers costs of cocktails, dinner and entertainment.

(Check, payable to Ohio State Medical Association, 79 E. State St., Columbus 15, for total cost of tickets ordered, must be enclosed.)

Name: (Please Print) .....

Street:..... City and Zone:.....

BE SURE YOUR NAME IS FILLED IN BEFORE MAILING BLANK

## THURSDAY, MAY 17

8:30 A. M. (E.S.T.)

### REGISTRATION

West Entrance Lobby, Exhibit Hall, Ground Floor
Veterans Memorial Building

9:00 to 9:30

### TOUR OF EXHIBITS

## THURSDAY, MAY 17

9:30 A. M.

### OHIO PSYCHIATRIC ASSOCIATION

Room G-20 (South Terrace), Exhibit Floor
Veterans Memorial Building

### THE PARTICIPANTS

E. H. Crawfis, M. D., Cleveland, President, Ohio Psychiatric Association.

Eugene W. Green, M. D., Columbus, Associate Professor, Department of Psychiatry, Ohio State University College of Medicine.

J. Robert Hawkins, M. D., Cincinnati, Assistant Professor of Psychiatry, University of Cincinnati College of Medicine.

David T. Matia, Cleveland, Member, Ohio House of Representatives.

Frank J. Merrick, Cleveland, Judge, Probate Court of Cuyahoga County.

Philip E. Piker, M. D., Cincinnati, President-Elect, Ohio Psychiatric Association.

9:30 Admission Procedures and Psychiatric Hospitalization with Special Reference to Experiences Under H. B. 529 (Panel Discussion)

Moderator: Dr. Piker.

Members of Panel: Mr. Mattia, Judge Merrick, Drs. Hawkins and Crawfis.

10:30 Recess for Tour of Exhibits.

11:00 Business Sessions, O.P.A. and O.S.M.A. Section on Nervous and Mental Diseases.

12:00 Adjournment.

Luncheon

(Time and place to be announced)

Localization of Psychic and Emotional Function—Dr. Green.

The foregoing program was arranged under the direction of the following: E. H. Crawfis, M. D., Cleveland, President, Irwin N. Perr, M. D., Cleveland, Secretary, Charles Fuess, M. D., Cincinnati, Program Chairman, Ohio Psychiatric Association.

(See page 337 for program of Section on Nervous and Mental Diseases.)

## THURSDAY, MAY 17

9:30 A. M. (E.S.T.)

### GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

### THE PARTICIPANTS

Program presented by the Faculty, Ohio State University College of Medicine.

Bertha A. Bouroncle, M. D., Associate Professor, Department of Medicine.

Ernest W. Johnson, M. D., Associate Professor and Director, Division of Physical Medicine and Rehabilitation, Department of Medicine.

Samuel Saslaw, M. D., Ph.D., Professor, Department of Medicine.

Dante G. Scarpelli, M. D., Ph. D., Assistant Professor, Department of Pathology.

William S. Smith, M. D., Professor and Director, Division of Orthopedic Surgery, Department of Surgery.

John C. Ullery, M. D., Professor and Chairman, Department of Obstetrics and Gynecology.

Warren E. Wheeler, M. D., Professor, Department of Pediatrics.

Roger D. Williams, M. D., Associate Professor, Department of Surgery.

Presiding: John D. Battle, Jr., M. D., Cleveland Member, Committee on Scientific Work.

9:30 Symposium on Backache

Moderator: Dr. Smith.

Back Pain from the General Surgeon's Viewpoint—Dr. Williams.

The Examination of the Back—Dr. Smith.

Physical Treatment of Low Back Pain—Dr. Johnson.

The Problem of Low Back Pain in Gynecology—Dr. Ullery.

10:30 Recess for Tour of Exhibits.

11:00 Virus Diseases—1962.

Moderator: Dr. Saslaw.

Clinical and Laboratory Aids in the Diagnosis of Newer Viral Diseases—Dr. Wheeler.

The Present Status of Viruses in Cancer Dr. Bouroncle.

Present Concepts of the Pathogenesis of Viral Diseases—Dr. Scarpelli.

Therapy and Prophylaxis of Virus Infections—Dr. Saslaw.

12:00 Adjournment.

Program arranged by the Postgraduate Medical Education Committee, Ohio State University College of Medicine.

## THURSDAY, MAY 17

12:30 P. M. (E.S.T.)

### OHIO NEUROSURGICAL SOCIETY LUNCHEON

Columbus Athletic Club
136 East Broad Street

(See Page 338 for program of Section on Neurological Surgery and the Ohio Neurosurgical Society, 2:00 P. M., Room 205, Veterans Wing, Second Floor, Veterans Memorial Building.)

## THURSDAY, MAY 17

2:00 P. M. (E.S.T.)

### INTERNAL MEDICINE

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

Program sponsored jointly by the Section on Internal Medicine and the Ohio Society of Internal Medicine.

### THE PARTICIPANTS

Stefan S. Fajans, M. D., Ann Arbor, Mich., Professor of Internal Medicine, Division of Endocrinology and Metabolism and the Metabolic Research Unit, University of Michigan Medical School.

Jules Hirsch, M. D., New York, N. Y., Associate Professor, Physician to the Hospital, Rockefeller Institute and Hospital.

Presiding: Dr. Ryan.

2:00 Aids in the Differential Diagnosis of Spontaneous Hypoglycemia—Dr. Fajans.

2:45 Discussion.

3:00 Recess for Tour of Exhibits.

3:30 Studies on the Dietary Management of Serum Lipid Disorders—Dr. Hirsch.

4:15 Discussion.

4:30 Election of Officers for 1963.

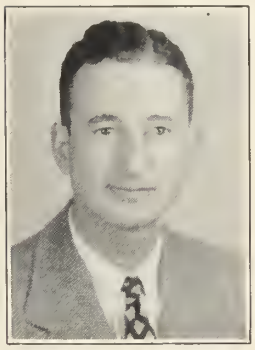
5:00 Adjournment for program of the Ohio Society of Internal Medicine at the Deshler Hilton Hotel.

6:00 (Deshler Hilton Hotel)
Cocktails and dinner (Dutch treat basis).

Speaker: Albert V. Whitehall, Executive Director, American Society of Internal Medicine.

The foregoing program was arranged under the direction of the following: Joseph M. Ryan, M. D., Columbus, Chairman, Clayton R. Sikes, M. D., Cincinnati, Secretary, Section on Internal Medicine; and Theodore L. Bliss, M. D., Akron, Program Chairman, Ohio Society of Internal Medicine.

## Guest Participants



Stafan S. Fajans, M. D.
Ann Arbor, Mich.



Jules Hirsch, M. D.
New York, N. Y.

## THURSDAY, MAY 17

2:00 P. M. (E.S.T.)

### NERVOUS AND MENTAL DISEASES

Room G-20 (South Terrace), Exhibit Floor
Veterans Memorial Building

Program sponsored jointly by the Section on Nervous and Mental Diseases and the Ohio Psychiatric Association.

### THE PARTICIPANTS

Adolf Haas, M. D., Columbus, Assistant Professor of Psychiatry, Ohio State University College of Medicine.

Leopold Liss, M. D., Columbus, Associate Professor of Psychiatry and Pathology, Ohio State University College of Medicine.

John H. Mitchell, M. D., Columbus, Instructor of Psychiatry, Ohio State University College of Medicine.

Mary S. Stahly, M. D., Columbus, Assistant Professor of Psychiatry, Ohio State University College of Medicine.

2:00 Management of the Psychiatric Patient in the Hospital—Dr. Haas.

2:20 Pseudo-Allergy and Psychiatric Disorders Dr. Mitchell.

2:40 Combined Outpatient Approach to the Problem Drinker—Dr. Stahly.

3:00 Recess for Tour of Exhibits.

3:30 Neuronal Differentiation in Vitro—Dr. Liss.

4:00 Guest speaker to be announced.

5:00 Adjournment.

The foregoing program was arranged under the direction of the following: E. H. Crawfis, M. D., Cleveland, Irwin N. Perr, M. D., Cleveland, Chairman and Secretary, respectively, of the Section on Nervous and Mental Diseases and the Ohio Psychiatric Association; and Charles D. Feuss, Jr., M. D., Cincinnati, Program Chairman, Ohio Psychiatric Association.

(See page 336 for program of Ohio Psychiatric Association.)

## THURSDAY, MAY 17

2:00 P. M. (E.S.T.)

### NEUROLOGICAL SURGERY

Room 205, Veterans Wing, Second Floor
Veterans Memorial Building

Program sponsored jointly by the Section on Neurological Surgery and the Ohio Neurosurgical Society.

### THE PARTICIPANTS

William F. Collins, M. D., Cleveland, Associate Professor, Department of Neurosurgery, Western Reserve University School of Medicine.

Lowell E. Ford, M. D., Cincinnati, Christ Hospital.

Robert B. King, M. D., Syracuse, N. Y., Professor, Department of Neurosurgery, State University of New York Upstate Medical Center.

Frank H. Mayfield, M. D., Cincinnati, Clinical Assistant Professor, University of Cincinnati College of Medicine.

Robert L. McLaurin, M. D., Cincinnati, Assistant Professor, University of Cincinnati College of Medicine.

Hans F. Plaut, M. D., Columbus, Clinical Assistant Professor, Department of Radiology, Ohio State University College of Medicine. (By invitation.)

Charles W. Rossel, M. D., Columbus, Instructor-Resident, Division of Neurosurgery, Ohio State University College of Medicine.

Martin P. Sayers, M. D., Columbus, Clinical Assistant Professor, Division of Pediatric Neurosurgery, Ohio State University College of Medicine.

Presiding: Dr. Hunt.

2:00 **Nerve Approaches to Craniostenosis**—Dr. Sayers.

2:20 **Pantopaque Studies of Cerebrospinal Fluid**—Dr. Collins.

2:40 **Relations of the Tentorium to Major Intracranial Vessels**—Dr. Plaut.

3:00 Recess for Tour of Exhibits.

3:30 **Physiology and Pharmacology of Tic Douloureux**—Dr. King.

4:00 **A Radiographic Study of Cerebral Circulation in Experimental Increased Intracranial Pressure**—Dr. Rossel.

4:20 **Mechanisms and Pathophysiology in Extradural Hematoma**—Drs. McLaurin and Ford.

4:40 **Anterior Discotomy for Spondylosis**—Dr. Mayfield.

5:00 Election of Officers for 1963.

The foregoing program was arranged under the direction of the following: William E. Hunt, M. D., Columbus, George T. Booth, M. D., Toledo, Chairman and Secretary, respectively, of the Section on Neurological Surgery and the Ohio Neurosurgical Society.

6:30 P. M. (E.S.T.)

Kahiki Restaurant
3583 East Broad Street
Cocktails and banquet.

## Guest Participants



A. E. Rakoff, M. D.
Philadelphia, Pa.



William C. Frayer, M. D.
Philadelphia, Pa.

## THURSDAY, MAY 17

2:00 P. M. (E.S.T.)

### OBSTETRICS AND GYNECOLOGY

Room 201, Veterans Wing, Second Floor
Veterans Memorial Building

### THE PARTICIPANTS

Stephen Hornstein, M. D., Cincinnati, Assistant Professor of Obstetrics, University of Cincinnati College of Medicine.

A. E. Rakoff, M. D., Philadelphia, Pa., Professor of Gynecologic Endocrinology, Jefferson Medical College of Philadelphia.

Kenneth J. Ryan, M. D., Cleveland, Arthur H. Bill Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine.

Nichols Vorys, M. D., Columbus, Instructor of Obstetrics and Gynecology, Ohio State University College of Medicine.

2:00 **Use of Cortico-Steroids in Clinical Obstetrics and Gynecology**—Dr. Rakoff.

3:00 Recess for Tour of Exhibits.

3:30 **How We Manage It.**

Symposium on common gynecological problems encountered in medical practice. Subjects covered will be: amenorrhea, dysmenorrhea, endometriosis, functional bleeding, oral contraceptives and others. Questions will be encouraged.

Moderator: Dr. Rakoff.

Participants: Drs. Ryan, Vorys and Hornstein.

5:00 Election of Officers for 1963.

5:15 Adjournment.

The foregoing program was arranged under the direction of the following: Henry A. Burstein, M. D., Toledo, Chairman, James H. Williams, M. D., Columbus, Secretary, Section on Obstetrics and Gynecology.

## THURSDAY, MAY 17

2:00 P. M. (E.S.T.)

### OPHTHALMOLOGY

Rooms 203-204, Veterans Wing, Second Floor
Veterans Memorial Building

Program sponsored jointly by the Section on Ophthalmology and the Ohio Ophthalmological Society.

### THE PARTICIPANTS

James E. Bennett, M. D., Cleveland, Senior Clinical Instructor of Ophthalmology, Western Reserve University School of Medicine.

William C. Frayer, M. D., Philadelphia, Pa., Assistant Professor of Ophthalmology, University of Pennsylvania School of Medicine.

Roscoe J. Kennedy, M. D., Cleveland, Head of the Department of Ophthalmology, Cleveland Clinic Foundation Hospital.

Torrence A. Makley, Jr., M. D., Columbus, Professor of Ophthalmology, Ohio State University College of Medicine.

John L. Roberts, M. D., Toledo, Director of Ophthalmology, St. Vincent's Hospital.

E. J. Wenaas, M. D., Youngtown, Emeritus Staff, St. Elizabeth Hospital.

Presiding: Dr. Edwards.

2:00 Extraction of Cataracts of Soft Lenses—Dr. Frayer.

3:00 Recess for Tour of Exhibits.

3:30 Reconstruction of the Bony Orbit Using Methyl Methacrylate—Dr. Bennett.

3:40 Cataract Extraction Under Duress (Panel Discussion)

Moderator: Dr. Kennedy.

Members of Panel: Drs. Frayer, Roberts, Wenaas and Makley.

4:50 Election of Officers for 1963.

5:00 Adjournment.

The foregoing program was arranged under the direction of the following: Thomas L. Edwards, M. D., Lima, Chairman, Section on Ophthalmology and President, Ohio Ophthalmological Society; Torrence A. Makley, Jr., M. D., Columbus, Secretary, Section on Ophthalmology and Ohio Ophthalmological Society; and Robert H. Magnuson, M. D., Columbus, Corresponding Secretary, Ohio Ophthalmological Society.

## THURSDAY, MAY 17

2:00 P. M. (E.S.T.)

### OTORHINOLARYNGOLOGY

Rooms 206-207, Veterans Wing, Second Floor
Veterans Memorial Building

### THE PARTICIPANTS

Harold E. Harris, M. D., Cleveland, Chief, Department of Otolaryngology, Cleveland Clinic.

William H. Havener, M. D., Columbus, Professor of Ophthalmology, Ohio State University College of Medicine.

Leonard L. Lovshin, M. D., Cleveland, Department of Internal Medicine, Cleveland Clinic.

Walter H. Maloney, M. D., Cleveland, Associate Professor and Director, Department of Otolaryngology, Western Reserve University School of Medicine.

Dwight M. Palmer, M. D., Columbus, Professor of Psychiatry and Anatomy, Ohio State University College of Medicine.

William C. Thornell, M. D., Cincinnati, Instructor of Otolaryngology, University of Cincinnati College of Medicine.

Fred R. Tingwald, M. D., Cleveland, Department of Otolaryngology, Cleveland Clinic.

2:00 Headache and Face Pain (Panel Discussion)

Moderator: Dr. Harris.

Members of Panel: Drs. Tingwald, Palmer, Havener and Lovshin.

3:00 Recess for Tour of Exhibits.

3:30 Round Table Discussion

Moderator: Dr. Harris.

Participants: Drs. Tingwald, Palmer, Havener and Lovshin.

4:00 Vocal Cord Paralysis—Dr. Thornell.

4:15 Chronic Cough—Dr. Maloney.

4:30 Election of Officers for 1963.

The foregoing program was arranged under the direction of the following: William H. Saunders, M. D., Columbus, Chairman, Harold E. Harris, M. D., Cleveland, Secretary, Section on Otorhinolaryngology.

## Guest Speakers

Planners of the program have reached far and wide to bring Ohio physicians the best talent from colleagues in other states. Read the program carefully and note the number of guest speakers who are scheduled to speak in various sessions. Here is your opportunity to hear these speakers from other states.

Make a point to chat with your favorite detail men several times during the Annual Meeting. You'll find them in the Technical Exhibits where supply houses have much to show you.

## THURSDAY, MAY 17

2:00 P. M. (E.S.T.)

### CONFERENCE ON LABORATORY MEDICINE

Lower Mezzanine Lounge
Veterans Memorial Building

Program sponsored by the Committee on Laboratory Medicine of the Ohio State Medical Association.

### THE PARTICIPANTS

Gerald L. Baum, M. D., Cincinnati, Chief, Pulmonary Disease Section, Veterans Administration Hospital.

Marilyn Blee, M. T. (ASCP), Cincinnati, Medical Technologist, Serology, Jewish Hospital Clinical Laboratories.

Leon Goldman, M. D., Cincinnati, Professor of Dermatology, University of Cincinnati College of Medicine.

E. A. Kindel, Jr., M. D., Cincinnati, Chief Resident, Department of Dermatology, University of Cincinnati College of Medicine.

Jan Schwarz, M. D., Cincinnati, Associate Director of Clinical Laboratories, Jewish Hospital.

Judith Toby, M. T. (ASCP), Cincinnati, Chief Technologist, Bacteriology, Jewish Hospital Clinical Laboratory.

Presiding: Dr. Davidson.

Mycology

2:00 **Serological Procedures**—Mrs. Blee.

2:15 **Cultural Procedures**—Miss Toby

2:30 **Selection and Collection of Specimens for Mycologic Diagnosis**—Dr. Kindel.

2:45 Discussion Period.

3:00 Recess for Tour of Exhibits.

3:30 **Superficial Mycoses and Comments on Treatment**—Dr. Goldman.

4:00 **Deep Mycoses and Comments on Treatment**—Dr. Baum.

4:30 **Laboratory Applications in Diagnosis and Treatment of Mycoses**—Dr. Schwarz.

5:00 Adjournment.

The foregoing program was arranged under the direction of the following members of the Committee on Laboratory Medicine of the Ohio State Medical Association: Horace B. Davidson, M. D., Columbus, Chairman; Edward L. Burns, M. D., Toledo; John B. Hazard, M. D., Cleveland; Melvin Oosting, M. D., Dayton; Arthur E. Rappoport, M. D., Youngstown; William B. Smith, M. D., Zanesville; Philip B. Wasserman, M. D., Cincinnati.

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### Order Your Tickets Early For President's Ball

Remember that the President's Ball on Wednesday evening is an outstanding feature of the Annual Meeting. Order tickets early. On one of the accompanying pages is a special coupon and instructions on how to get your reservations in early.

## THURSDAY, MAY 17

3:30 P. M. (E.S.T.)

### OHIO CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIANS

Room 202, Veterans Wing, Second Floor
Veterans Memorial Building

Program sponsored jointly by the Ohio Chapter of the American College of Chest Physicians and the Ohio State Medical Association.

### THE PARTICIPANTS

Neil C. Andrews, M. D., Columbus, Associate Professor, Division of Thoracic Surgery, Ohio State University College of Medicine.

Andrew L. Banyai, M. D., Chicago, Ill., Emeritus Clinical Professor of Medicine, Marquette University (Milwaukee).

Harriet P. Dustan, M. D., Cleveland, Member of Staff, Cleveland Clinic Hospital.

Karl P. Klassen, M. D., Columbus, Professor of Surgery, Ohio State University College of Medicine.

Edwin R. Levine, M. D., Chicago, Ill., Assistant Professor of Clinical Medicine, Chicago Medical School.

John H. Mitchell, M. D., Columbus, Clinical Professor of Medicine, Ohio State University College of Medicine.

Thomas K. Oliver, M. D., Columbus, Associate Professor of Pediatrics, Ohio State University College of Medicine.

Presiding: Dr. Tomashefski.

3:30 **Pulmonary Cavities**—Dr. Andrews.

4:00 **Etiology and Management of Hypertension Associated with Renal Occlusive Vascular Disease**—Dr. Dustan.

4:30 Business Meeting, Ohio Chapter.

5:00 Adjournment for continuation of program in the Junior Ballroom, Mezzanine Floor, Neil House.

5:30 (Neil House) Cocktails.

6:00 Dinner.

7:00 **Management of the Cardiopulmonary Cripple** (Panel Discussion)

Moderator: Dr. Banyai.

Members of Panel: Drs. Klassen, Levine, Mitchell and Oliver.

8:00 Adjournment for Fireside Conferences on Cardio-Respiratory Diseases, in the Grand Ballroom, Neil House.

The foregoing program was arranged under the direction of the following: Joseph Tomashefski, M. D., Columbus, President, F. G. Kravec, M. D., Youngstown, Secretary, and Howard S. Van Ordstrand, M. D., Cleveland, Ohio Chapter, American College of Chest Physicians.

## THURSDAY, MAY 17

8:00 P. M. (E.S.T.)

## FIRESIDE CONFERENCES ON CARDIO-RESPIRATORY DISEASES

Grand Ballroom, Mezzanine Floor
Neil House

The Fireside Conferences are being presented jointly by the Ohio State Medical Association and the Ohio Chapter of the American College of Chest Physicians. A panel of experts will be seated at each of eleven tables, and physicians attending are encouraged to circulate and to ask questions, express their own ideas and comment on the various problems of the subject under discussion. They may move from one table to another if and when they wish. Refreshments will be served with the compliments of the American College of Chest Physicians.

1. **Tuberculosis**
   Moderator: Joseph B. Stocklen, M. D., Cleveland.
   Lynne Baker, M. D., Dayton
   Robert H. Browning, M. D., Columbus
   Harold G. Curtis, M. D., Cleveland
   Harold I. Humphrey, M. D., Columbus

2. **Chronic Bronchitis and Emphysema**
   Moderator: John A. Prior, M. D., Columbus
   William R. Biddlestone, M. D., Cleveland
   George O. Kress, M. D., Columbus
   Edwin R. Levine, M. D., Chicago
   Philip C. Pratt, M. D., Columbus

3. **Chest Roentgenology**
   Moderator: William Molnar, M. D., Columbus
   William E. Briggs, M. D., Columbus
   A. J. Christoforidis, M. D., Columbus
   Norman M. Glazer, M. D., Akron
   Thomas F. Meaney, M. D., Cleveland

4. **Industrial Chest Diseases**
   Moderator: Bertram D. Dinman, M. D., Columbus
   Edward Arnold, M. D., Canton
   Sidney I. Franklin, M. D., Youngstown
   Howard S. Van Ordstrand, M. D., Cleveland
   Constantine Vishnevsky, M. D., Canton

5. **Coronary Artery Disease**
   Moderator: Noble O. Fowler, M. D., Cincinnati
   Robert A. Helm, M. D., Cincinnati
   Ray W. Kissane, M. D., Columbus
   George I. Nelson, M. D., Columbus
   Henry A. Zimmerman, M. D., Cleveland

6. **Cardiopulmonary Disability Evaluation and Work Classification**
   Moderator: David G. Gillespie, M. D., Cleveland
   Marvin Fish, M. D., Columbus
   Philip W. Smith, M. D., Marion
   James T. Taguchi, M. D., Dayton
   Richard L. Witt, M. D., Cincinnati

*(Continued in Next Column)*

## Guest Participants



Andrew L. Banyai, M. D.
Chicago, Ill.



Edwin R. Levine, M. D.
Chicago, Ill.

7. **Intrathoracic Tumors**
   Moderator: Maurice G. Buckles, M. D., Columbus
   William H. Falor, M. D., Akron
   Elmer R. Maurer, M. D., Cincinnati
   Charles V. Meckstroth, M. D., Columbus
   Harvey J. Mendelsohn, M. D., Cleveland

8. **Cardiovascular Surgery**
   Moderator: Earle B. Kay, M. D., Cleveland
   Jay L. Ankeney, M. D., Cleveland
   Samuel A. Marable, M. D., Columbus
   Howard D. Sirak, M. D., Columbus
   John Storer, M. D., Cleveland

9. **Hypertension—Systemic and Pulmonary**
   Moderator: Harriet P. Dustan, M. D., Cleveland
   Arthur C. Corcoran, M. D., Cleveland
   Irwin B. Hanenson, M. D., Cincinnati
   Joseph M. Ryan, M. D., Columbus
   James F. Schieve, M. D., Columbus

10. **Rheumatic Heart Disease**
    Moderator: Frederick S. Cross, M. D., Cleveland
    Hugh N. Bennett, M. D., Youngstown
    Don M. Hosier, M. D., Columbus
    Edward A. Mortimer, Jr., M. D., Cleveland
    Maurice A. Schnitker, M. D., Toledo

11. **Fungus Diseases**
    Moderator: Samuel Saslaw, M. D., Ph. D., Columbus
    Robert J. Atwell, M. D., Columbus
    Gerald L. Baum, M. D., Cincinnati
    Roy L. Donnerberg, M. D., Columbus
    Dieter Koch-Weser, M. D., Cleveland

# Separate Events of Specialty Groups At Time of OSMA Annual Meeting

IN addition to co-sponsoring programs of the Scientific Sections, many of the specialty groups in Ohio, also, are holding meetings independently of, but in addition to, the section sessions during the week of May 14-18, when the Ohio State Medical Association will hold its Annual Meeting in Columbus. These consist of scientific programs, business meetings and social events.

This development will be one of the new features of the 1962 Annual Meeting of the Ohio State Medical Association. It will coordinate the scientific activities of many of Ohio's specialty groups with the program of the Ohio State Medical Association. However, it also provides ample opportunity for the specialty groups to have sessions just for their own members, if they desire, the same week as the annual meeting.

Following is information concerning the independent events of the specialty groups which are meeting in Columbus the week of the OSMA Annual Meeting:

Wednesday, May 16

**Ohio State Heart Association:** Deshler Hilton Hotel, 12:30 P. M. Business session starting with a luncheon for delegates and board members, followed by the annual membership meeting and the board of trustees meeting.

Thursday, May 17

**Ohio Psychiatric Association:** (Time and place to be announced.) Luncheon. Dr. Eugene W. Green, Columbus, will talk on "Localization of Psychic and Emotional Function," following the luncheon.

**Ohio Neurosurgical Society:** Columbus Athletic Club, 136 East Broad St., 12:30 P. M., luncheon.

**Ohio Neurosurgical Society:** Kahiki Restaurant, 3583 East Broad Street, 6:30 P. M., cocktails and banquet.

**Jefferson Medical Alumni Reunion:** University Club, 40 South Third Street, "fellowship hour," 6 P. M., dinner at 7:30 P. M.

**Ohio Society of Internal Medicine:** Deshler Hilton Hotel, 6 P. M., cocktails and dinner (Dutch treat basis). Speaker: Mr. Albert V. Whitehall, San Francisco, Cal., Executive Director, American Society of Internal Medicine.

**Ohio Chapter, American College of Chest Physicians:** Neil House, Junior Ballroom, Mezzanine Floor, 5:30 P. M., cocktails; 6 P. M., dinner.

Friday, May 18

**Ohio Society of Pathologists:** The Maramor, 137 East Broad Street, 5:30 P. M., business meeting; 6 P. M., social hour; 7 P. M. dinner.

**Ohio Society of Physical Medicine:** Olentangy Inn, 1299 Olentangy River Road, 7 P. M., cocktails and dinner.

Saturday, May 19

**Ohio Chapter, American Academy of Pediatrics:** Nationwide Inn, 4101 West Broad Street. Scientific program, 10 A. M., "Pulmonary Physiology and the Respiratory Distress Syndrome," Thomas K. Oliver, M. D., Columbus, Associate Professor, Department of Pediatrics, Ohio State University College of Medicine; 10:30 A. M., "Drug Therapy in the Newborn and Premature," James M. Sutherland, M. D., Cincinnati, Assistant Professor of Pediatrics, University of Cincinnati College of Medicine; 11 A. M., "Recent Advances in the Study of Chromosomal Anomalies," Josef Warkany, M. D., Cincinnati, Professor of Research Pediatrics, University of Cincinnati College of Medicine; 11:30 A. M., business meeting; 12 Noon, adjournment.

**Ohio Orthopaedic Society:** Stouffer's University Inn, 2900 Olentangy River Road. Program and business session during the day. Address by Dr. Philip D. Wilson, Director of Research, Surgeon-in-Chief Emeritus, Hospital for Special Surgery, New York, on "Whither Orthopedics?". Details relative to the program will be published in a later issue of *The Journal*.

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### Premedical Honor Society To Meet in Toledo

Alpha Epsilon Delta, the international premedical honor society, will hold its 14th national convention April 26-28, at The University of Toledo, Toledo, Ohio. In addition to the business sessions of the convention which will be held on Thursday and Saturday, the Society will sponsor a conference on "Career Opportunities in Medicine and Dentistry" to be held on Friday, April 27th.

**FRIDAY, MAY 18**

8:30 A. M. (E.S.T.)

**REGISTRATION**

West Entrance Lobby, Exhibit Hall, Ground Floor
Veterans Memorial Building

9:00 to 9:30

**TOUR OF EXHIBITS**

**FRIDAY, MAY 18**

9:30 A. M. (E.S.T.)

**GENERAL SESSION**

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

**THE PARTICIPANTS**

W. A. Altemeier, M. D., Cincinnati, Christian R. Holmes Professor of Surgery and Chairman of the Department of Surgery, University of Cincinnati College of Medicine.

H. D. Bruner, M. D., Washington, D. C., Assistant Director for Medical and Health Research, Division of Biology and Medicine, U. S. Atomic Energy Division.

Arthur C. DeGraff, M. D., New York, N. Y., Samuel A. Brown Professor of Therapeutics, New York University College of Medicine.

Walter J. Frajola, Ph.D., Columbus, Professor of Pathology and Physiological Chemistry, Ohio State University College of Medicine.

Walter H. Pritchard, M. D., Cleveland, Director of Cardiology, University Hospitals.

William C. Weir, M. D., Cleveland, Assistant Clinical Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine.

Warren E. Wheeler, M. D., Columbus, Professor of Pediatrics and Microbiology, Ohio State University College of Medicine.

Presiding: Maurice A. Schnitker, M. D., Toledo, Chairman, Committee on Scientific Work.

9:30 What's New?

In Long-Term Anticoagulant Therapy —Dr. Pritchard.

In Use of Vaccines—Dr. Wheeler.

In Enzymes in Diagnosis—Dr. Frajola.

In Oral Antiovulatory Agents — Dr. Weir.

In Antibiotic Prophylaxis——Dr. Altemeier.

10:30 Recess for Tour of Exhibits.

11:00 Some Important Aspects of the Newer Drugs—Dr. DeGraff.

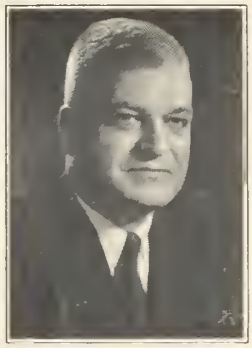
11:30 Radiation Hazards—Dr. Bruner.

12:00 Adjournment.

## Guest Participants



H. D. Bruner, M. D.
Washington, D. C.



Orville T. Bailey, M. D.
Chicago, Ill.

**FRIDAY, MAY 18**

1:30 P. M. (E.S.T.)

**PATHOLOGY**

Room G-20 (South Terrace), Exhibit Floor
Veterans Memorial Building

Program sponsored jointly by the Section on Pathology and the Ohio Society of Pathologists.

1:30 Tissue Reactions to Ionizing Irradiation in the Central Nervous System—Orville T. Bailey, M. D., Chicago, Ill., Professor of Neurology, University of Illinois College of Medicine.

2:30 Slide Seminar—Dr. Bailey.

3:00 Recess for Tour of Exhibits.

3:30 Continuation of Slide Seminar.

5:00 Adjournment for business meeting, social hour and dinner at The Maramor, Banquet Room, 137 East Broad Street.

5:30 (The Maramor)
Business Meeting.

6:00 Social Hour.

7:00 Dinner.

The foregoing program was arranged under the direction of the following: Horace B. Davidson M. D., Columbus, Chairman, Section on Pathology, and President, Ohio Society of Pathologists; L. J. McCormack, M. D., Cleveland, Secretary, Section on Pathology, and Secretary-Treasurer, Ohio Society of Pathologists; J. M. B. Bloodworth, M. D. and Leopold Liss, M. D., Columbus, Local Committee on Arrangements.

### Extra Meeting Scheduled?

A number of small groups usually arrange a dinner, social event or program during the Annual Meeting. Some of these affairs appear in the program. Other organizations are invited to leave information at the Registration desk as to time, place, etc., so that data may be passed to members who inquire there.

## FRIDAY, MAY 18

2:00 P. M. (E.S.T.)

### GENERAL PRACTICE OF MEDICINE
### OCCUPATIONAL MEDICINE
### PHYSICAL MEDICINE
### RADIOLOGY

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

Program sponsored jointly by the Sections on General Practice of Medicine, Physical Medicine, and Radiology and the Ohio Society of Physical Medicine and Rehabilitation.

### THE PARTICIPANTS

Judson S. Millhon, M. D., Internist, Columbus

Arthur K. Peterson, M. D., Chicago, Ill., Medical Director, R. R. Donnelley & Sons Company.

Juan M. Taveras, M. D., New York, N. Y., Professor of Radiology, Columbia University College of Physicians and Surgeons.

Jerome S. Tobis, M. D., New York, N. Y., Chief, Division of Rehabilitation Medicine, Montefiore Hospital.

Rex H. Wilson, M. D., Akron, Medical Director, B. F. Goodrich Company.

Presiding: Dr. Wilson.

The Management of Cerebral Vascular Accidents

2:00 **The Effective Management of Strokes**—Dr. Millhon.

2:30 **Roentgenologic Diagnosis of Cerebral Vascular Lesions**—Dr. Taveras.

3:00 Recess for Tour of Exhibits.

3:30 **Rehabilitation of the Hemiplegic**—Dr. Tobis.

4:00 **Returning to Work after a Stroke**—Dr. Peterson.

4:30 Round-table Discussion.
Moderator: Dr. Wilson.

5:00 Election of Officers for 1963.

5:10 Adjournment.

The foregoing program was arranged under the direction of the following: Allan L. Wasserman, M. D., Dayton, Chairman, Sol Maggied, M. D., West Jefferson, Secretary, Section on General Practice of Medicine; Shelley M. Strain, M. D., Cleveland, Chairman, William F. Ashe, M. D., Columbus, Secretary, Section on Occupational Medicine; Richard F. Baer, M.D., Toledo, Chairman, Hilda B. Case, M. D., Cleveland, Secretary, Section on Physical Medicine; Robert L. Friedman, M. D., Columbus, Chairman, Atis K. Freimanis, M. D., Columbus, Secretary, Section on Radiology; and Charles Long II, M. D., Cleveland, President, Roswell Lowry, M. D., Cleveland, Secretary, Ohio Society of Physical Medicine and Rehabilitation.

7:00 P. M. (E.S.T.)

Ohio Society of Physical Medicine

Olentangy Inn
1299 Olentangy River Road

Cocktails and Dinner

## Guest Participants



Arthur K. Peterson, M. D.
Chicago, Ill.



Juan M. Taveras, M. D.
New York, N. Y.

## FRIDAY, MAY 18

2:00 P. M. (E.S.T.)

### ANESTHESIOLOGY

Rooms 206-207, Veterans Wing, Second Floor
Veterans Memorial Building

### THE PARTICIPANTS

Ali Gharib, M. D., Cleveland, Assistant Professor of Anesthesiology, Western Reserve University School of Medicine.

William Hamelberg, M. D., Columbus, Professor and Director, Division of Anesthesia, Ohio State University College of Medicine.

Leslie Rendell-Baker, M. D., Cleveland, Assistant Professor of Anesthesiology, Western Reserve University School of Medicine.

Respiratory Problems in Anesthesiology

2:00 **Preoperative Pulmonary Problems**—Dr. Gharib.

2:30 **Respiratory Problems in the Traumatic Patient**—Dr. Hamelberg.

3:00 Recess for Tour of Exhibits.

3:30 **Postoperative Phase**—Dr. Rendell-Baker.

4:00 Discussion.

4:30 Election of Officers for 1963.

The foregoing program was arranged under the direction of the following: Roland L. Kennedy, M. D., Toledo, Chairman, and Walter B. Wildman, II, M. D., Cincinnati, Secretary, Section on Anesthesiology.

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Remember, the Technical Exhibits are as varied as the medical supply field is broad. Watch those "Recesses" in the program and make a point to visit the exhibits often.

## FRIDAY, MAY 18

2:00 P. M. (E.S.T.)

### ORTHOPAEDIC SURGERY

Rooms 203-204, Veterans Wing, Second Floor
Veterans Memorial Building

Program sponsored jointly by the Section on Orthopaedic Surgery and the Ohio Orthopaedic Society

### THE PARTICIPANTS

Paul H. Curtiss, Jr., M. D., Cleveland, Department of Orthopaedic Surgery, Western Reserve University School of Medicine.

J. George Furey, M. D., Cleveland, Clinical Professor of Orthopaedic Surgery, Western Reserve University School of Medicine.

Nicholas J. Giannestras, M. D., Cincinnati, Chairman, Department of Orthopaedics and Fractures, Good Samaritan Hospital.

Alfred W. Humphries, M. D., Cleveland, Associate Professor of Vascular Surgery, Frank E. Bunts Educational Institute, Cleveland Clinic.

George S. Phalen, M. D., Cleveland, Associate Professor of Orthopaedic Surgery, Frank E. Bunts Educational Institute, Cleveland Clinic.

Philip D. Wilson, M. D., New York, N. Y., Director of Research, Surgeon-in-Chief Emeritus, Hospital for Special Surgery.

Presiding: Dr. Lacey.

2:00 **The Use of Hip Prosthesis in Femoral Neck Fractures**—Dr. Furey.

2:20 Discussion.

2:25 **Salvage of the Unsatisfactory Prosthetic Hip**—Dr. Wilson.

2:55 Question Period.

3:00 Recess for Tour of Exhibits.

3:30 **Acute Calcification in the Wrist and Hand**—Dr. Phalen.

3:45 Discussion.

3:50 **Treatment of Plantar Callosities** — Dr. Giannestras.

4:10 Discussion.

4:15 **Femoral Head Changes in Sickle Cell Disease**—Dr. Curtiss.

4:35 Discussion.

4:40 **The Reversibility of Pre-Gangrenous Conditions of the Extremities**—Dr. Humphries.

5:05 Discussion.

5:15 First Executive Meeting of the Ohio Orthopaedic Society; and Election of O.S.M.A. Section Officers for 1963.

The foregoing program was arranged under the direction of the following: Henry B. Lacey, M. D., Columbus, Jack W. Millis, M. D., Toledo, officers of the Section on Orthopaedic Surgery and the Ohio Orthopaedic Society; Paul R. Miller, M. D., Columbus, Chairman of the Program Committee; and Carl R. Coleman, M. D., Columbus, Chairman of the Committee on Local Arrangements.

## Guest Participant



Philip D. Wilson, M. D.
New York, N. Y.

## FRIDAY, MAY 18

2:00 P. M. (E.S.T.)

### PEDIATRICS

Room 201, Veterans Wing, Second Floor
Veterans Memorial Building

Program sponsored jointly by the Section on Pediatrics and the Ohio Chapter, American Academy of Pediatrics.

### THE PARTICIPANTS

Orville C. Green, M. D., Columbus, Assistant Professor, Department of Pediatrics, Ohio State University College of Medicine.

Harold Kalter, Ph.D., Cincinnati, Assistant Professor of Research Pediatrics, University of Cincinnati College of Medicine.

Thomas K. Oliver, M. D., Columbus, Associate Professor, Department of Pediatrics, Ohio State University College of Medicine.

James M. Sutherland, M. D., Cincinnati, Assistant Professor of Pediatrics, University of Cincinnati College of Medicine.

Josef Warkany, M. D., Cincinnati, Professor of Research Pediatrics, University of Cincinnati College of Medicine.

### Symposium on Fetus and Newborn

Moderator: Dr. Green.

2:00 **Maternal Disorders and Prenatal Development**—Drs. Warkany and Kalter.

2:45 Discussion Period.

3:00 Recess for Tour of Exhibits.

3:30 **Effects of Maternal Medication on the Fetus and Newborn**—Dr. Sutherland.

4:00 **The Influence of Environmental Temperature on the Metabolism of the Newborn**—Dr. Oliver.

4:30 Discussion Period.

4:45 Election of Officers for 1963.

5:00 Adjournment.

The foregoing program was arranged under the direction of the following: William D. DeVaux, M. D., Cincinnati, Chairman, William E. Baldock, M. D., Columbus, Secretary, Section on Pediatrics; Charles L. Shafer, M. D., Mansfield, President, and Robert D. Mercer, M. D., Cleveland, Secretary, Ohio Chapter, American Academy of Pediatrics.

## SCIENTIFIC AND EDUCATIONAL EXHIBIT

**The Scientific and Educational Exhibit will be open from 9:00 A. M. to 5:30 P. M. on Wednesday, May 16, Thursday, May 17, and from 9:00 A. M. to 3:30 P. M. on Friday, May 18.**

Following is a list of the Scientific and Educational Exhibit applications which had been reviewed and approved by the Committee on Scientific and Educational Exhibit on or before February 15. Additional exhibits will be listed in the official program distributed at the meeting.

The Hospital Cancer Registry
American Cancer Society, Ohio Division, Inc., Cleveland.

Renal Angiography: Necessity for Serial Films
Chester C. Winter, M. D., Ohio State University Health Center, Division of Urology, Columbus.

Peripheral Arteriosclerosis: Natural History and Results of Treatment
A. W. Humphries, M. D., V. G. deWolfe, M. D., F. A. LeFevre, M. D., J. R. Young, M. D., Cleveland Clinic.

Know Your Vitamins—Use Them Wisely
American Medical Association, Department of Foods and Nutrition, Chicago, Ill.

The Auto-Antibodies of Lupus Erythematosus
Donald J. Blaney, M. D., Ph.D., University of Cincinnati Medical Center.

Manifestations of Muscular Dystrophy
Muscular Dystrophy Associations of America, Inc., New York, N. Y.

Cancer of the Mouth
Henri LeClaire, M. D., Cincinnati.

Controlled Hypotension with Sodium Nitroprusside
Elmars M. Bitte, M. D., Patrick P. Moraca, M. D., Donald E. Hale, M. D., Carl E. Wasmuth and Eugene F. Poutasse, M. D., Cleveland Clinic.

Spectrum of Clinical Cytology
Emmerich von Haam, M. D., Eli Nadel, M. D., Ohio State University Medical Center and National Institutes of Health, Columbus, Ohio and Bethesda, Md.

Leukocytic Infiltration of the Umbilical Cord—Fetal Hypoxia vs. Infection
R. Dominguez, M. D., A. J. Segal, M. D., J. R. Collins, M. D., G. B. Hurd, M. D., Saint Luke's Hospital, Cleveland.

Ohio Maternal Statistics
Committee on Maternal Health, Ohio State Medical Association.

Hereditary Hemorrhagic Telangiectasia
William H. Saunders, M. D., Department of Otolaryngology, Ohio State University College of Medicine.

Diabetic Foot Lesions—A Successful Method of Healing
Joseph I. Goodman, M. D., Harvey Post, M. D., Irwin Frank, M. D., Alan Silver, M. D., Mount Sinai Hospital, Cleveland.

The Velocity Electrocardiogram
Milan Halmos, M. D., Bela Kolossvary, Ph.D., Elias Saadi, M. D., Leonard P. Caccamo, M. D., Cardiopulmonary Laboratory, St. Elizabeth Hospital, Youngstown, Thiel College, Greenville, Pa.

Vocational Rehabilitation in Ohio
Ohio Bureau of Vocational Rehabilitation, Columbus.

The Fate of Artificial Valves
Earle B. Kay, M. D., David Mendelsohn, Jr., M. D., H. A. Zimmerman, M. D., St. Vincent Charity Hospital, Cleveland.

Pyelonephritis
Department of Urology, University of Cincinnati College of Medicine, Arthur T. Evans, M. D., Director.

Chemotherapy of Metastatic Carcinoma of the Breast
Arnoldus Goudsmit, M. D., Curtis J. Fisher, M. D., Robert G. Warnock, M. D., Youngstown Hospital Association, Youngstown.

Bone Marrow Biopsy with Vim-Silverman Needle
S. L. Harder, M. D., J. D. Battle, Jr., M. D., L. J. McCormack, M. D., J. S. Hewlett, M. D., Cleveland Clinic.

Control of Bleeding Peptic Ulcer
Robert T. Murphy, M. D., Joseph L. Bilton, M. D., Edward A. Marshall, M. D., Huron Road Hospital, Cleveland.

Surgery of the Breast
Joseph A. Bonta, M. D., and Arthur G. James, M. D., Columbus.

*(Continued on Next Page)*

## SCIENTIFIC AND EDUCATIONAL EXHIBIT *(Continued)*

Filter Paper Urine Test Applied to Detection and Management of Phenylketonuria

George M. Guest, M. D., Helen K. Berry, Betty S. Sutherland, Children's Hospital Research Foundation, Cincinnati.

Patients Are Helped by Physical Therapists

The American Physical Therapy Association, Ohio State Chapter, Inc., Columbus.

Chemotherapy of Inoperable Carcinoma of the Lung

Jorge Medina, M. D., Cleveland.

Chemotherapy of Cancer

William G. Pace, M. D., Neil C. Andrews, M. D., David Lee Kinsey, M. D., Ohio State University Hospital, Columbus.

Diagnostic Virology in a General Hospital

The Department of Laboratories, Division of Virology, The Youngstown Hospital Association, Robert F. Tamburro, M. A. Head, and Arthur E. Rappoport, M. D., Director.

Anticoagulants—Yes or No?

Ohio State Heart Association, Columbus.

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# Deadline for Submission of Resolutions to Columbus Office of Association Is March 15

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions considered by the House of Delegates at the 1962 session in Columbus should heed the date March 15 and comply with the following:

1. Resolutions must be introduced at the First Session of the House of Delegates. The first session at the 1962 Annual Meeting, Neil House, Columbus, will be on Monday evening, May 14, starting with a dinner at 6 o'clock.

2. A resolution must be introduced in triplicate by a delegate or a duly accredited alternate who has been seated as a delegate due to the absence of a delegate. This must be done even though the resolution may have been published in *The Journal* or sent in writing to all delegates prior to the meeting.

3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least sixty (60) days prior to the first session of the House of Delegates. This requirement may be waived by a vote of at least two-thirds of the House of Delegates present at the first session.

4. To comply with the foregoing Constitutional provision on introduction of resolutions, resolutions for the 1962 Annual Meeting must be in the hands of the Executive Secretary on or before MARCH 15.

5. Resolutions received will be published in *The Journal* prior to the meeting and copies will be distributed in advance of the meeting to members of the House of Delegates to give them an opportunity to discuss resolutions with their constituents and possibly to receive voting instructions from their County Medical Society.

# TECHNICAL EXHIBITORS

## EXHIBITION HALL, GROUND FLOOR, VETERANS MEMORIAL BUILDING

**Open from 9:00 A.M. to 5:30 P. M. on Wednesday and Thursday, May 16, 17; and from 9:00 A. M. to 3:30 P. M. on Friday, May 18.**

| Exhibitor | Address | Booth No |
|---|---|---|
| Abbott Laboratories, | North Chicago, Ill. | 20 |
| Aloe, A. S., Company, | St. Louis, Mo. | 16 |
| Ames Company, Inc., | Elkhart, Ind. | 77 |
| Ayerst Laboratories, Div. of American Home Products Corp., | Arlington, Va. | 74 |
| Baker Laboratories, Inc., The, | Cleveland, Ohio | 86 |
| Breon Laboratories, Inc., | New York, N. Y. | 95 |
| Brewer & Company, Inc., | Worcester, Mass. | 25 |
| Bristol Laboratories, Div. of Bristol Myers Co., | New York, N. Y. | 62 |
| Burroughs Wellcome & Co., (U.S.A.) Inc., | Tuckahoe, N. Y. | 46 |
| Cameron Surgical Instruments Co., | Chicago, Ill. | 59 |
| Camp, S. H., & Company, | Jackson, Mich. | 84 |
| Chattanooga Pharmacal Company, Inc., | Chattanooga, Tenn. | 55 |
| Ciba Parmaceutical Products, Inc., | Summit, N. J. | 17 |
| Coca-Cola Company, The, | Atlanta, Ga. | 41 |
| Columbus Hospital Supply Company, | Columbus, Ohio | 65, 66 |
| Desitin Chemical Company, | Providence, R. I. | 40 |
| Dietene Company, The, | Minneapolis, Minn. | 79 |
| Eaton Laboratories, Div. of The Norwich Pharmacal Co., | Norwich, N. Y. | 71 |
| Encyclopaedia Britannica, | Chicago, Ill. | 99 |
| Endo Laboratories, | Richmond Hill, N. Y. | 12 |
| Erdman, Marshall, & Associates, Inc., | Madison, Wisconsin | 30 |
| Gallagher-Roach & Company, | Columbus, Ohio | 47 |
| Geigy Pharmaceuticals, | Ardsley, N. Y. | 10 |
| Gerber Products Company, | Fremont, Mich. | 75 |
| Great Books of the Western World, | Cincinnati, Ohio | 42 |
| Heinz, H. J., Company, | Pittsburgh, Pa. | 57 |
| Holland-Rantos Company, Inc., | New York, N. Y. | 53 |
| International Latex Corporation, | New York, N. Y. | 27 |
| Lederle Laboratories, Div. American Cyanamid Co., | Pearl River, N. Y. | 58 |
| Lilly, Eli, and Company, | Indianapolis, Ind. | 52 |
| Lippincott, J. B., Company, | Philadelphia, Pa. | 19 |
| Lloyd, Dabney & Westerfield, Inc., | Cincinnati, Ohio | 31 |
| Loma Linda Food Company, | Arlington, Cal. | 14, 90 |
| Massachusetts Indemity and Life Insurance Co., | Boston, Mass. | 44 |
| Massengill, S. E., Company, | Bristol, Tenn. | 28 |
| Mead Johnson Laboratories, | Evansville, Ind. | 23 |
| Medco Products by Belco Distributing Co., | Cleveland, Ohio | 29 |
| Medical Protective Company, The, | Fort Wayne, Ind. | 21 |
| Merck Sharp & Dohme, Div. of Merck & Co., Inc., | West Point, Pa. | 34 |
| Mutual Benefit Life Insurance Co., The, | Newark, N. J. | 81 |
| Mutual of Omaha, C.H.F. Swisher Agency, | Columbus, Ohio | 33 |
| Ohio Bell Telephone Company, The, | Cleveland, Ohio | 48 |
| Ohio Medical Indemnity, Inc., | Columbus, Ohio | 70 |
| Ortho Pharmaceutical Corporation, | Raritan, N. J. | 11 |
| Oyster Business Equipment Co., Soundscriber, | Columbus, Ohio | 92 |
| Parke, Davis & Company, | Detroit, Mich. | 80 |
| Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc., | New York, N. Y. | 73 |
| Philips Roxane, Inc., | Columbus, Ohio | 60 |
| Prindaville Company, The, | Columbus, Ohio | 32 |
| Purdue Frederick Company, The, | New York, N. Y. | 15 |
| Reed & Carnrick, | Kenilworth, N. J. | 68 |

*(Continued on Next Page)*

## TECHNICAL EXHIBITORS (Continued)

| Exhibitor | Address | Booth No. |
|---|---|---|
| Roche Laboratories, | Nutley, N. J. | 26 |
| Roerig, J. B. and Company, | New York, N. Y. | 87 |
| Ross Laboratories, | Columbus, Ohio | 102 |
| Sanborn Company, | Waltham, Mass. | 61 |
| Sandoz Pharmaceuticals, | Hanover, N. J. | 18 |
| Saunders, W. B., Company, | Philadelphia, Pa. | 1 |
| Schieffelin & Co., | New York, N. Y. | 82 |
| Schmid, Julius, Inc., | New York, N. Y. | 13 |
| Scroggins, Clayton L., Associates, | Cincinnati, Ohio | 8 |
| Searle, G. D., & Company, | Chicago, Ill. | 85 |
| Smith Kline & French Laboratories, | Philadelphia, Pa. | 97 |
| Squibb, E. R., & Sons, Division of Olin Mathieson Chemical Corp., | New York, N. Y. | 9 |
| Stuart Company, The, | Pasadena, Cal. | 45 |
| Turner and Shepard, Inc., | Columbus, Ohio | 72 |
| Tutag, S. J., & Company, | Detroit Mich. | 78 |
| U. S. Standard Products Company, | Mount Prospect, Ill. | 67 |
| U. S. Vitamin & Pharmaceutical Corporation, | New York, N. Y. | 98 |
| Upjohn Company, The, | Kalamazoo, Mich. | 24 |
| Vercoe & Company, | Columbus, Ohio | 91 |
| Wallace Laboratories, Div. of Carter Products, Inc., | New Brunswick, N. J. | 56 |
| Wampole Laboratories, | Stamford, Conn. | 69 |
| Warren-Teed Products Company, The, | Columbus, Ohio | 22 |
| Wendt-Bristol Co., The, | Columbus, Ohio | 63, 64 |
| Westwood Pharmaceuticals, | Buffalo, N. Y. | 54 |
| Winthrop Laboratories, | New York, N. Y. | 76 |
| Wocher, Max & Son Company, The | Cincinnati, Ohio | 35 |

### Attorneys Cannot Incorporate Under S. B. 550

The Ohio Supreme Court has held that lawyers cannot form a corporation to practice law, under provisions of S. B. 550.

It denied Merritt W. Green, Toledo attorney, an order to compel Secretary of State Ted W. Brown to incorporate two professional associations to practice law.

The court said its rules provide that only "natural persons" may be admitted to law practice in Ohio.

Green sought the incorporations under a new law (Senate Bill 550) providing for "professional associations" for rendering professional services.

This Supreme Court ruling has no effect on associations of other professional men, physicians, dentists, architects, engineers, optometrists, etc.

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Children under five years of age will be the prime target for the first National Poison Prevention week, to be observed March 18-24.

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The Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine will hold the eighth annual Symposium on Cardiovascular Diseases in Louisville, Ky., Brown Hotel, March 28-29. Inquiries may be addressed to the organization at 333 Guthrie St., Room 311, Louisville 2, Kentucky.

### Liver Disease Is Subject For Cleveland Course

The Frank E. Bunts Educational Institute affiliated with the Cleveland Clinic Foundation has announced a postgraduate course in Clinical Fundamentals of Liver Disease, to be held March 7 and 8. Several outstanding guest speakers as well as local physicians will participate in the program. Details may be obtained by contacting the Institute at 2020 East 93rd Street, Cleveland.

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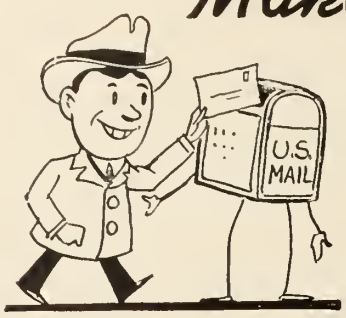
### Misbranding Charges Follow Broadcasts by Fredericks

Radio broadcasts by self-styled "nutritionist" Carlton Fredericks about the health benefits of vitamin, mineral and other food supplements have caused the misbranding of 43 such products marketed by Foods Plus, Inc., a mail-order distributor, the Food and Drug Administration has charged.

FDA's charges were filed in the Federal District Court at Newark, N. J., in a seizure case that ties up a large part of the firm's inventory, the agency said.

FDA said Fredericks recommended many substances for the treatment of serious conditions over the air and that his recorded commercials plugged Foods Plus products containing them. The agency charged the Foods Plus articles were misbranded because they do not include adequate directions for the treatment of these diseases.

# Make Hotel Reservations Now!




for the

## 1962 ANNUAL MEETING OF THE OHIO STATE MEDICAL ASSOCIATION

## May 14, 15, 16, 17, and 18

## COLUMBUS

*Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing*

| NAME AND LOCATION | SINGLE | DOUBLE | TWIN |
|---|---|---|---|
| NEIL HOUSE, 41 S. High St. (Headquarters Hotel) | $ 7.00- 9.50 | $ 9.50-12.00 | $12.00-15.00 |
| DESHLER HILTON HOTEL, W. Broad & N. High | $ 7.50-14.00 | $12.00-15.00 | $13.50-20.00 |
| PICK-FORT HAYES HOTEL, 31 W. Spring St. | $ 8.00- 9.50 | $11.00-12.00 | $14.00 up |
| HOTEL SOUTHERN, S. High & E. Main Sts. | $ 7.50- 8.00 | $10.00-10.50 | $11.00-12.50 |

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

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HOTEL RESERVATION BLANK
Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14-18, 1962, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Other

Arriving May.....at.....A. M.....P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

# Woman's Auxiliary Annual Meeting, Deshler Hilton Hotel

THE Woman's Auxiliary to the Ohio State Medical Association will hold its annual meeting concurrently with that of the OSMA in Columbus. Meetings are scheduled in the Deshler Hilton Hotel in downtown Columbus. Board meetings are scheduled on Monday, May 14, with the general meetings and special features beginning on Tuesday and extending through Thursday noon.

Mrs. Lester W. Sontag, Yellow Springs, is president of the Auxiliary. Convention Chairman is Mrs. Norris Lenahan; co-chairmen are Mrs. A. F. Slivinski and Mrs. H. J. Wynsen, all of Columbus.

The program has been announced as follows:

**MONDAY, MAY 14**

| | |
|---|---|
| 9:00 A. M. | Budget Committee Meeting |
| 10:30 A. M. | Resolution Committee Meeting |
| 11:00 A. M. | Finance Committee Meeting |
| 11:00 A. M. | Registration Board Members and Local Committee Members |
| 1:00 P. M. | Hospitality Room |
| 1:30 P. M. | Pre-Convention Board Meeting |
| 6:00 P. M. | Reception and Dinner for Board of Directors |
| 8:00 P. M. | Board Meeting |

**TUESDAY, MAY 15**

| | |
|---|---|
| 8:30 A. M. | Registration Opens; closes 4:00 P. M. |
| 8:30 A. M. | Hospitality Room opens; closes 4:00 |
| 9:00 A. M. | General Session, Mrs. L. W. Sontag, President, presiding |
| | Address by Guest Speaker, Thomas E. Rardin, M. D., Columbus |
| 12:00 Noon | Ladies' Day Luncheon—Style Show |
| 2:30 P. M. | General Session<br>The County In Action |

**WEDNESDAY, MAY 16**

| | |
|---|---|
| 8:30 A. M. | Registration opens; closes 4:00 P. M. |
| 8:30 A. M. | Hospitality Room opens; closes 4:00 |
| 9:00 A. M. | General Session, Mrs. L. W. Sontag, President, presiding |
| | Address by Guest Speaker, Mrs. Harlan English, President, Woman's Auxiliary to American Medical Association |
| 12:45 P. M. | Doctors' Day Luncheon |
| | Free Afternoon |
| 6:30 P. M. | OSMA President's Ball, Neil House |

**THURSDAY, MAY 17**

| | |
|---|---|
| 8:30 A. M. | Registration opens; closes 12:00 noon |
| 8:30 A. M. | Hospitality Room opens; closes noon |
| 9:00 A. M. | General Session, Mrs. L. W. Sontag, President, presiding |
| | Guest Speaker, George J. Hamwi, M. D., President of the Ohio State Medical Asocition |
| | Installation of Officers |
| 11:30 A. M. | Brunch, Sky Room<br>Post-Convention Board Meeting |

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## Accident Mortality for 1961 Was at All Time Low

The year 1961 established a milestone in the accident record of the American people.

It was the first time that the accident death rate in the United States dipped as low as 50 per 100,000 population, which is about 3 per cent under the previous low set in 1960, according to statisticians of the Metropolitan Life Insurance Company.

Provisional figures show that the actual accident death toll was about 91,500 lives in 1961, which represents a decrease of approximately 1,500 from the year before.

This relatively favorable record reflects to a considerable degree, a reduced number of deaths from accidents in and about the home, statisticians said. About 26,500 persons were killed in such mishaps during 1961, or approximately 1,000 below the number of similar deaths recorded the year before.

Motor vehicle fatalities, which numbered about 38,000 in 1961, also dropped under the 1960 toll.

# Increase of $5.00 in Annual Dues Is Recommended by The Council

MEETING on December 16, 1961, The Council of the Ohio State Medical Association by a unanimous vote adopted a resolution recommending to the House of Delegates that the annual per capita dues be increased by $5.00, making the dues $35.00, effective January 1, 1963. This recommendation will be presented to the House of Delegates at the 1962 Annual Meeting in Columbus, May 14-18. The following statement has been prepared by The Council to inform the membership of the necessity for this increase in dues. Copies of the statement will be transmitted to the secretary of each County Medical Society with a request that it be discussed at a meeting of the society; Also, copies will be sent to delegates who will represent the County Societies at the Annual Meeting in May.

## THE COUNCIL'S STATEMENT

"To: Members of the House of Delegates:

"By a unanimous vote, The Council of the Ohio State Medical Association, on December 16, 1961, authorized the preparation of the following statement for consideration by the House of Delegates at the 1962 Annual Meeting, May 14-18, Columbus:

"In order to maintain the present efficiency of the Ohio State Medical Association and to insure its continued progress at a time when a strong, effective organization to serve the physicians of Ohio is imperative, The Council recommends that the House of Delegates should adopt the following resolution, specifically for reasons set forth in the accompanying statement:

"**Resolved, That the per capita annual dues of the Ohio State Medical Association shall be increased from $30.00 to $35.00, effective January 1, 1963.**

"A careful study of the activities and the financial picture of the Association reveals that the present income of the Association is not adequate to insure the maintenance of some of our activities and programs at par; to allow growth, progress and planning for the future; to meet unexpected developments; and to cushion the Association against inflation.

"This study has convinced The Council that the present activities and services of the Association are necessary and are beneficial to the 9,500 members of the Association, individually and collectively. For these reasons The Council believes they should be continued and expanded, where necessary, not curtailed or eliminated; and that this is the desire of the membership generally.

"As a matter of fact, it is our opinion that the membership wants their Association to assume new responsibilities and be prepared, through expanded activities, to meet the challenges of not only today but of tomorrow. We believe the members support our stand that the Association dare not stand still.

"Moreover, we believe that the membership realizes that expansion will require some increase in financial outlay.

"The Council is opposed to deficit financing. A moderate increase in per capita dues will allow reasonable expansion, proper budgeting, and maintenance of the Association's reserves for emergencies which may develop.

"Following are some data which in the opinion of The Council justify its conviction that an increase in the per capita annual dues is not only desirable, but necessary.

"**BUDGET:** Expenditures in 1960 exceeded the budget by $498. Although the amount was small it indicates how difficult it is to keep expenditures and budget in balance because of increasing costs of Association activities. Obviously, The Council had to draft a very "tight" budget for 1962, making no allowance for new or expanded activities.

"**PERSONNEL:** In order to keep pace with new activities authorized by the House of Delegates or The Council, and the new demands made on our 25 active committees, it has been necessary to employ a new administrative assistant. He started work in January. This was done with a look toward the future. When some of our veteran employees retire, we want experienced persons ready to take over.

"It has been necessary to keep our staff salaries adjusted to current economic and business conditions prevailing in the Columbus area. We have an office staff of 18 which is second to none — competent, loyal and experienced. It is vital that we retain such personnel by providing them with up-to-date

equipment, good working environment and adequate salaries. This we have tried to do.

"Salary adjustments have added to our annual expenditures. We must be prepared for additional expenditures of this nature, as we have to compete with others for the services of reliable and efficient persons. Service is the Association's most important product. It takes competent personnel to insure first-class service. The payroll is one of the most important items in our budget.

"In the 1962 budget, totalling $296,760, the Association payroll amounts to $110,000. This does not include a payroll of $26,200 for four members of the staff whose salaries are charged against The Ohio State Medical Journal and the annual honorarium paid the Editor of *The Journal*.

"RENT: In order to provide the Columbus Office staff and *The Journal* staff with adequate space, we have leased additional space adjacent to our present quarters. This gives us about 4100 square feet of office space at an annual rental under a five-year lease, negotiated in July, 1961, of $12,750.

"THE JOURNAL: Publication of *The Journal* is not only one of our indispensable activities, but one of our most costly. Printing costs which are tied into labor costs of the printing industry show a gradual increase year after year. We have no control over this. The income of *The Journal* annually from advertising is just about enough to meet the actual costs of printing the magazine. This does not take into consideration payroll of *The Journal* staff, mailing costs, costs of engravings and miscellaneous expenditures which have to be borne by a contribution from the Association to *The Journal* each year.

"We have not been lax in boosting advertising rates from time to time, but such increases are never able to keep pace with publishing costs. Also, we can't afford to price ourself out of the market by charging unreasonable advertising rates.

"In 1961, the advertising revenue of *The Journal* was about 23 per cent less than the advertising revenue in 1960 and several previous years — a situation common to all State Medical Journals. Some improvement, but not much, is anticipated in 1962. Therefore, it was necessary to budget $39,000 from Association funds as a subsidy to *The Journal* for 1962. We may find it unnecessary to spend all of this amount. Any unexpended balance will revert to the general funds of the Association.

"Every possible way to economize on publication of *The Journal* is being tried. At the same time, we are being careful to see that the high standard of *The Journal* is not being jeopardized. This is one of our main channels of communication to our members. We can't risk cheapening it.

"Therefore, we must face the fact that in all probability the Association will be confronted always with the necessity of making a substantial financial contribution to *The Journal* each year. Some years it will be more; some less, depending on the fluctuation of advertising income and printing costs.

"In the calendar year 1961, the total costs of Journal operations, including salaries, was approximately $160,000 of which $82,000 was paid out for printing, $2,000 for illustrations and engravings; $3,800 for stationery, reprints and supplies; and $1,400 for postage.

"AMA DELEGATES AND ALTERNATES: By action of the House of Delegates, the Association is obligated to reimburse not only AMA delegates, but alternate delegates as well, for a substantial part of their expenses in attending the two annual sessions of the AMA House of Delegates. This is a new expense, effective January 1, 1962. The AMA delegates' expenses have been totalling between $6,000 and $6,500 annually. Now that the expenses of alternate delegates also will be paid by the Association, this budget item has been doubled for 1962. This will have to be taken into account also in setting up budgets for future years.

"LEGAL EXPENSES: Association matters requiring legal review and legal advice have multiplied greatly in recent years. These include questions involving professional ethics; disciplinary actions; interpretations of local and state constitutions and bylaws; analysis of legislative proposals; testimony by legal counsel before legislative committees; advice on business matters involving the administration of the affairs of the Association, i. e., tax matters, leases, official documents.

"Here again we have an item which varies from year to year, depending on the number of questions submitted to legal counsel and how intricate they are. We have found it wise, as well as necessary, to employ the best of legal counsel. Such services are indispensable. We must be prepared at all times to secure, as well as pay for legal counsel on whom we can depend for a good job. Legal expenses paid in 1961 totalled $16,500.

"ANNUAL MEETING COSTS: Usually our income from technical exhibits has been sufficient to pay the costs of the Annual Meeting, the cost of which runs about $25,000. Nevertheless, we cannot be sure of this because of increases in these costs, such as transportation and accommodations for our guest speakers; rental of convention space; labor involved in setting up the Scientific Exhibit — one of the big features of the meeting and a costly item —; events where meals are served; printing and postage involved in pre-convention promotion, etc.

"For these reasons, we are forced to carry a substantial item in our budget for Annual Meeting expenses and be prepared to meet any difference between revenue from exhibits and meeting expenses out of general funds. The day when we could be sure of

adding some of the exhibit income to reserves has about disappeared.

"COMMITTEE ACTIVITIES: Because of added impetus to many of our activities, and because of reference of many items to committees for study by the House of Delegates or Council, it has been necessary to hold meetings of many of our committees more often. Committee members are reimbursed for transportation and hotel expenses and other out-of-pocket expenses. More meetings add to committee expense.

"Also, some of our committees have, with the approval of Council, presented some of their studies and reports in the form of brochures to facilitate distribution to the membership and to the public. Printing costs being what they are, this has added to the costs of committee work.

"Committee work is the very heart of our numerous activities. Unless committees can meet often and are allowed sufficient money to do a good job, the Association's services and programs will suffer. During the past several years we have added seven new committees, making the total number of committees 25, each of which is doing an essential job for the Association. Several years ago when the naming of these committees was authorized by the House of Delegates, The Council advised the membership that more revenue might be needed to finance committee activities, once these new committees got into high gear. That time has arrived. Expenditures for committee activities in 1961 totalled about $12,000. Larger committee expenditures in the future should be anticipated as a speedup in committee work appears to be a certainty.

"TRAVEL COSTS AND REIMBURSABLE EXPENSES: Costs of transportation, hotel accommodations and food have increased considerably and will continue to increase. This has added not only to the costs of committee activities — it has added to the cost of field work on the part of our Columbus Office staff and to costs involved in having staff members or physicians officially represent the Association at national and regional meetings.

"Reimbursable expenses incurred during 1961 by members of the office staff and the President and President-Elect, primarily for field work and attending district, state and national meetings totalled approximately $11,000. This does not include reimbursement to the members of The Council for travel within their districts and for expenses in attending Council meetings, aggregating about $5,700. Such expenses are bound to increase under prevailing economic conditions.

"POSTAGE, TELEPHONE AND TELEGRAPH: Lines of communication between the Columbus Office and our 9,500 members, individually or through the officers and committeemen of our 88 county medical societies, are essential to the success of the Association's programs. In 1961, the postage bill of the Association for first, third and fourth class mail was approximately $4,900. This amount does not include the cost of mailing *The Journal* and the *OSMAgram* which are mailed under a second-class bulk mailing permit. Congress has before it a bill to authorize a substantial increase in postal rates. The forecast is that it will be enacted. Therefore, we can look forward to a substantial increase in OSMA postage costs.

"In addition to postage costs, we must take into consideration amounts needed for telephone and telegraph services. In 1961, these totalled approximately $3,700. No decrease in this amount should be anticipated. An increase would appear to be a distinct probability.

"DISTRICT CONFERENCES: Since the last increase in dues was authorized by the House of Delegates — in 1959 — a new and very popular feature has been added to the Association's activities — the Councilor District Conferences. These are being held in the Fall of each year at 11 places throughout the state. Those invited to attend these gatherings, consisting of a dinner and discussion session, are the president, president-elect or vice-president, secretary-treasurer, and legislative and public relations chairmen of the county medical societies. Representing the State Association have been the president, president-elect, councilor and members of the Columbus Office executive staff. State and national issues are discussed as well as local problems. Much valuable information is exchanged. Suggestions are made to the county officials as to how they can meet local problems or improve their county society activities. As indicated, both local and state officials have found these sessions to be productive of much good for medical organization generally. There is a concerted demand that they be continued. The cost of this project is about $3,500 annually.

"RETIREMENT PENSION FUND: Eight of our employees are now covered by our retirement pension program which has been in effect since 1947. Five years of service are required for eligibility to participate in this program. Two employees became eligible during the past two years. Several additional employees will be taken into the program during the next several years if normal conditions prevail. This year the Association is paying approximately $8,500 into the retirement pension fund. It is likely that this amount will increase during the next several years. This program has been an important factor in securing and retaining mature, experienced and efficient employees.

"LITERATURE; MISCELLANEOUS PRINTING; SUPPLIES: Each year the Association finds itself called upon to provide more and more literature of all kinds, not only to members, but to many lay organizations and groups. This is a part of our public relations and health education programs. The general increase in printing costs has been reflected

in what we have had to pay to obtain or produce pamphlets and brochures.

"It would be unwise for us to retrench in this field of communications. In fact, we should be prepared to expand, as it is imperative for us to keep our members and the public informed of medicine's views on subjects of public interest and to see that the public gets facts and sound advice on medical-health subjects.

"This has become exceedingly more vital in recent years because of the critical situation which has confronted the medical profession on the Federal Legislative front.

"Another budget item which has shown a gradual increase over the years has been the cost of stationery and supplies. The amount used is bound to increase as the activities of the Association and its membership expand. In 1961, this item cost the Association about $6,000.

"DUES OF OTHER STATE SOCIETIES: With one exception — Virginia — each of the 51 constituent medical societies of the American Medical Association has per capita annual dues larger than the current $30 dues of the Ohio State Medical Association. Following is a tabulation of the annual dues of the constituent societies, prepared on information obtained in December, 1961:

| *State* | *1962 Dues* | *State* | *1962 Dues* |
|---|---|---|---|
| Alabama | $ 50.00 | Montana | $ 65.00 |
| Alaska | 75.00 | Nebraska | 35.00 |
| Arizona | 85.00 | Nevada | 100.00 |
| Arkansas | 35.00 | New Jersey | 35.00 |
| California | 75.00 | New Mexico | 90.00 |
| Colorado | 60.00 | New York | 35.00 |
| Connecticut | 33.00 | North Carolina | 50.00 |
| Delaware | 50.00 | North Dakota | 100.00 |
| District of Columbia | 70.00 | Ohio | 30.00 |
| Florida | 40.00 | Oklahoma | 47.00 |
| Georgia | 40.00 | Oregon | 50.00 |
| Hawaii | 60.00 | Pennsylvania | 60.00 |
| Idaho | 83.00 | Puerto Rico | 52.00 |
| Illinois | 80.00 | Rhode Island | 50.00 |
| Indiana | 50.00 | South Carolina | 35.00 |
| Iowa | 90.00 | South Dakota | 100.00 |
| Kansas | 50.00 | Tennessee | 40.00 |
| Kentucky | 50.00 | Texas | 45.00 |
| Louisiana | 50.00 | Utah | 85.00 |
| Maine | 55.00 | Vermont | 65.00 |
| Maryland | 50.00 | Virginia | 25.00 |
| Massachusetts | 35.00 | Washington | 45.00 |
| Michigan | 80.00 | West Virginia | 38.00 |
| Minnesota | 55.00 | Wisconsin | 90.00 |
| Mississippi | 50.00 | Wyoming | 50.00 |
| Missouri | 35.00 | | |

"CONCLUSION: The foregoing data do not present to the membership an all-inclusive report of the Association's activities. It engages in many which are not even mentioned. The intent was to merely present some of the high spots of the OSMA operations; to show how they are now being financed; why additional revenue is deemed necessary in order to keep these activities functioning on an efficient basis.

The final decision rests with the membership, speaking through their duly elected delegates. We believe the members are proud of their Association and have a right to be. We believe they will want to provide it with the means to continue its effective work and expand its programs to meet the challenges of the future."

*The Council*
*Ohio State Medical Association.*

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## Advances in General Medicine Is One of Several Courses Scheduled in Columbus

A symposium on Recent Advances in General Medicine is being sponsored by the Central Ohio Academy of General Practice in cooperation with the Ohio State University College of Medicine on Sunday, March 18, at the Neil House in Columbus. Other University-sponsored courses also have been announced.

Registration for the March 18 program opens at 9:00 a. m. with the first program feature at 10:00 o'clock. Topics and speakers have been announced as follows:

Proctoscopy and Diseases To Consider, J. Peerman Nesselrod, M. D.

Current Concepts of Cystic Fibrosis, Robert J. Atwell, M. D.

Current Status of Chemotherapy in Cancer, Jeanne C. Bateman, M. D.

Questions and Panel Discussion.

Luncheon — Luncheon speaker will be Heinz von Foerster, Ph. D., whose topic will be "The Population Explosion."

The Immunologist Looks at Host Resistance, Thomas G. Ward, M. D.

Viral Encephalitides, Samuel Saslaw, M. D.

Measles Vaccination, Saul Krugman, M. D.

Status of Live Polio Vaccine Immunization, Robert N. Barr, M. D.

Questions and Panel Discussion.

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### Claim Statement on Diapulse Is Exaggerated

The Medical and Scientific Committee of The Arthritis and Rheumatism Foundation is of the opinion that the publicity now being given to the device known as "Diapulse" as a "dramatic breakthrough in the treatment of arthritis" or "the best treatment of arthritis now available" with all the connotations that go with such statements is not in the best interest of the patients with this affliction or their physicians. It is the opinion of the MSC that the evidence from clinical trials to date does not warrant these statements.

# Buckeye News Notes . . .

**Alliance**—The Alliance-Salem Area Life Underwriters Association recently heard Dr. J. L. McClintock speak concerning the problems and relationships of doctors and underwriters, fee schedules, medical care for the aged and socialized medicine.

**Bethel**—Dr. Albert W. Van Sickle is the new Clermont County health commissioner. He comes to Ohio from Air Force Hospital, Maxwell Air Force Base, Montgomery, Alabama.

**Berea**—Dr. Paul H. Dube, local physician, recently left on a medical mission to Jordan in the Middle East. Dr. Dube will serve for a month in Jordan as a consultant for orthopedic surgery for crippled children.

**Cambridge**—The local council of R. &. S. Masons has awarded a 50-year jeweled pin to Dr. Henry L. Wells.

**Cincinnati**—The Institutum Divi Thomae has announced that the National Institutes of Health of the Dept. of Health, Education and Welfare has awarded the institute a three-year, $43,900 grant to continue studies of methods of fighting germs resistant to wonder drugs. Dr. Leo G. Nutini heads the institute's Division of Experimental Medicine.

**Cleveland**—The Academy of Medicine of Cleveland recently held a meeting for college students who are interested in the field of medicine. Questions pertaining to entrance requirements, costs and scholarships and other financial aid available were answered by representatives from Western Reserve University, Ohio State University, and The University of Cincinnati.

**Cleveland**—A medical mission to Liberia to carry out a large program of preventive inoculations and treatment of diseases is being organized by Dr. Robert A. Hingson, professor of anesthesia at Western Reserve University.

**Columbus** — Governor Michael DiSalle recently named Dr. C. Joseph Cross to the Ohio Wildlife Council for a term ending in February, 1964.

**East Liverpool**—Dr. Samuel Rich, who retired recently after 50 years as a physician and eye specialist, has been honored for "invaluable service and cooperation" by the East Liverpool Lions Club. This award was given Dr. Rich in appreciation for his aid in the club's sightsaving work among needy children.

**Lancaster**—Dr. J. L. Kraker, president of the Fairfield Heart Council, spoke at a recent Rotary Club meeting on the subject, "The Value of a Professional Association."

**Marietta**—Dr. C. A. S. Williams, retired Marietta physician, has been appointed to the Marietta City Board of Education. Dr. Williams is also a member of the Board of Health and serves on the advisory committee of the practical nursing program conducted by the city schools.

**Marion**—The first annual award for community distinguished service was presented to Dr. E. L. Brady by the United Community Services of Marion County.

**Malvern**—Dr. Joseph D. Stires, physician in the area for 32 years, was honored at a community gathering sponsored by the Order of Foresters. Some 320 persons attended the dinner program.

**Middletown**—Dr. Robert Tennant addressed the local Lions Club, contrasting in his talk government controlled and private enterprise medical practice and medical care plans.

**Mt. Vernon**—Dr. John Drake was presented the "Golden Deeds Award" for the year by the local Exchange Club.

**North Ridgeville**—Dr. Theodore E. Finegan has been elected North Ridgeville Council president at the first City Council meeting in city history. North Ridgeville was designated a city in August, 1961, to take effect January 1.

**Springfield** — Dr. John A. Davidson has been elected president of the Springfield Chamber of Commerce.

**Springfield**—Dr. Mary A. Agna has been appointed public health physician for Clark County.

**Springfield**—Dr. Richard J. Ireton described experiences on the medical ship *Hope* before a meeting of the Springfield Business and Professional Women's Club.

**St. Clairsville**—Dr. A. J. Antalis, Powhatan physician, has accepted the appointment as chairman for the 1962 American Red Cross membership and fund campaign in Belmont County.

**Van Wert**—Dr. E. W. Burnes was guest speaker at a recent meeting of the Van Wert County Medical Assistants Society. His topic was "Public Relations."

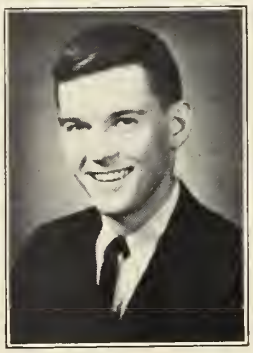
**Warren**—The Warren Board of Education has elected Dr. Clyde W. Muter president. Dr. Muter is presently serving his first term on the Board.

**Wooster**—Dr. James Roberts, Akron, was principal speaker at the Exchange Club meeting where he discussed dangers in a so-called free medical care program or government controlled medicine.

**Zanesville**—Dr. Robert Martin spoke before the local Kiwanis Club describing the program of the American Medical Association and the part it plays in the American health field.

## New Member of Columbus Office Staff

W. Michael Traphagan has joined the staff of the Columbus Office of the Ohio State Medical Association as administrative assistant.



Michael Traphagan

Mr. Traphagan, married and a native of Columbus, is a December graduate of Ohio State University with a bachelor degree in business administration, having a major in advertising and minor in English-journalism, specializing in public relations.

While attending the university, he became a member of Kappa Sigma and served as rush chairman, external relations chairman and secretary. He also served as public relations director for the Ohio Students' Party Associated, a campus political party. Traphagan also was Fall Sports Editor of the 1960 *Makio,* the OSU yearbook, and was a staff writer for the campus newspaper, *The Lantern.*

## New Guide for Parents On Epilepsy

A new 40-page pamphlet, "Diagnosis Epilepsy — A Guide for Parents," is now available to physicians for distribution to parents of children with this disorder.

Published by the Parents Committee on Epilepsy of the Family Health Association, Cleveland, the pamphlet was prepared under the guidance of an editorial advisory committee composed of physicians and representatives of the fields of social work, health education, psychology and nursing, as well as a parent familiar with problems posed by this diagnosis.

Nelson Richards, M. D., and Victor M. Victoroff, M. D., represented the Ad Hoc Committee on Epilepsy of the Academy of Medicine of Cleveland and Cuyahoga County in the editorial advisory group.

Written in lay language to provide parents with information about epilepsy problems, the publication stresses throughout the importance of the role of the physician in managing the condition.

Topics discussed, in six sections, are: (1) Why a Guide for Parents of Children with Epilepsy, (2) Toward Understanding Epilepsy, (3) Day-by-Day Living with Epilepsy, (4) The "Normal" and "Not so Normal" Personality, (5) Recreation and the Epileptic Child, and (6) Community Resources — and a Look to the Future.

It is believed to be the first such publication in the United States prepared especially for parents of epileptic children.

## Rehabilitation Advisory Committee Meets

The first meeting of the newly-formed Medical Advisory Committee of the State Bureau of Vocational Rehabilitation was held in Columbus last December 17. The members are: Drs. John A. Brown, Morristown, Richard D. Burk, Columbus, Herman K. Hellerstein, Cleveland, Jack W. Millis, Toledo, Mitchell R. Zavon, Cincinnati, and Glenn W. Zeiders, Canton. The Ohio State Medical Association assisted the Bureau's Director Mr. Edward J. Moriarty, in selecting the Committee.

The Committee, small in membership in order to afford a better chance to be a "working" group, was chosen on the basis of geography, special interests and desire to assist in strengthening the medical aspects of the Bureau's program.

Being advisory in nature rather than administrative, the Committee concerns itself with recommendations for developing relationships with the medical community to encourage more and earlier referrals of patients, the qualifications of medical personnel providing services to the Bureau's clients, a study of existing medical services policies, fee schedules, etc.

"What should be the largest source of client referrals — the physician — accounted for less than 6 per cent of the Bureau's total last year," said Dr. Domingo Cerra, Medical Administrative Consultant for the Bureau. "We hope to coordinate the Bureau's informational efforts with the Committee's recommendations to better inform the physician on the eligibility requirements and services available to the vocationally handicapped."

On April 14 a meeting of the Committee will be held in Columbus with the Bureau's fifteen part-time field office medical consultants. It will include an amputee clinic demonstration by the Committee on Prosthetics Education and Information of the National Academy of Sciences at the new Ohio Rehabilitation Center, Ohio State University Medical Center.

## Ohio Medical Assistants To Hold Annual Meeting in Cleveland

The Fifth Annual Convention of the Ohio State Society for Medical Assistants will be held at the Sheraton Cleveland Hotel, in Cleveland, May 25-27.

The Third Education Workshop will be held on May 25 and the convention on May 26 and 27. Theme of the meeting is "Towards Greater Understanding." Complete program and registration form will appear later.

Advance information about the meeting may be obtained from Miss Jean Klippert, convention chairman, or Miss Nancy Nigosian, publicity chairman, both located at 2065 Adelbert Road, Cleveland 6, O.

# Are You Eligible To Vote?...

## Primary Election Day Is May 8. But Deadline For Registration. Where Required. Is March 28

THIS is an all-important year in terms of elections. Every good citizen should determine now that he is eligible to vote in the Primaries, May 8, as well as in the General Election, November 6. Citizens will have the opportunity this year of voting for a U. S. Senator, Congressmen, Governor of Ohio and other State Officials, Judges of the Supreme Court, State Senators and Representatives, and county officers.

March 28 is the deadline for registration for those citizens who must register in order to vote in the May 8 Primaries.

Registration is a simple matter. Here are the points to be remembered, presented in question and answer form from information furnished by Ted W. Brown, Secretary of State:

**What is the registration deadline?**

Forty days before the Primary Election, or March 28.

**Who must register?**

Every citizen who resides in a "registration district" must be registered with his county Board of Elections before he is eligible to vote.

**What is a registration district?**

The County Board of Elections must maintain a registration of eligible voters in every city of 16,000 population or over. Municipalities of less than 16,000 population may elect to maintain registration. The Board of Elections of a county may require registration in the entire county or in certain precincts. A registration district, therefore, may be a county, a municipality, a group of precincts or a single precinct.

**How does a person know whether he is in a registration district or in a non-registration area?**

If he resides in a municipality of 16,000 population or over, he must be registered. If he resides in a suburban community, a small municipality or a rural area, and is in doubt, he should phone the county Board of Elections and ask.

**Under what conditions must a person reregister?**

Registration is permanent, subject to the following exceptions:

a. If the citizen has not voted in a general, primary or special election since January 1, 1960, he must register again.

b. If the citizen has changed name — e. g., if a woman has married — she must re-register. If a woman marries between March 28 and May 8, she may vote on May 8 under her former name.

c. A veteran of the armed services must register after he is discharged.

d. A voter who changes his place of residence from one county to another, must register with the Board in the county to which he moves if his new residence is in a registration precinct. A voter who changes his residence to a new address within a registration district must notify his Board of Elections of such change. Some boards require the voter to present himself in person; others accept written notice.

**What is the procedure for voters in non-registration areas?**

In precincts not in registration districts, citizens are automatically eligible to vote. A voter may be required at the polling booth to produce evidence to the satisfaction of the election judge, or under oath, that he is qualified to vote.

**What is the residence requirement for registration?**

A person who will have met the residence requirement for voting by May 8 — that is, will have lived in the State one year, in the county and precinct 40 days, and is otherwise qualified to vote — may register on or before March 28.

**If he has moved his residence between March 28 and Election Day, what can he do?**

Vote at the precinct from which he moved.

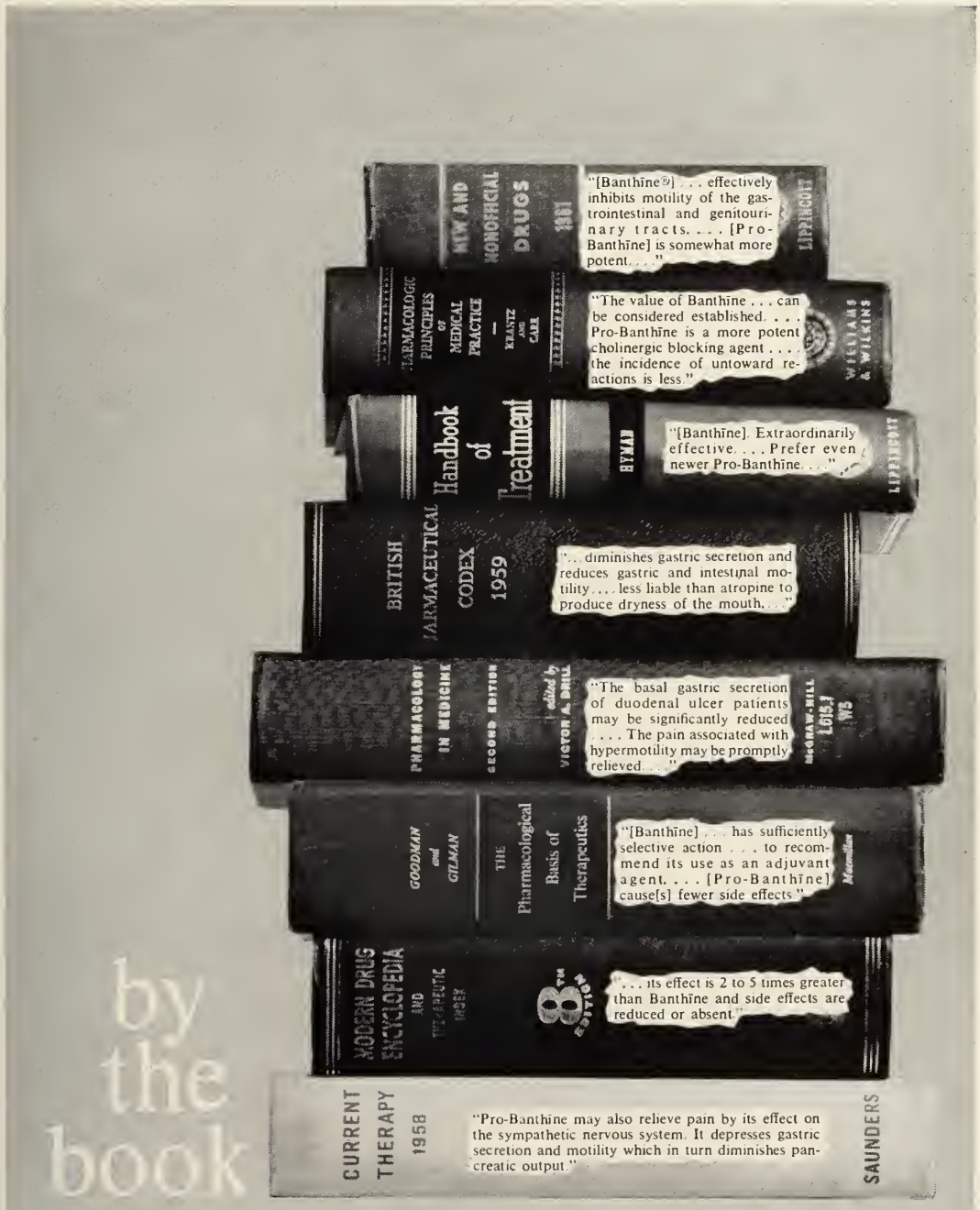
**If a citizen has moved or is planning to move prior to March 28 may he vote at the precinct in which he formerly resided?**

No. If he does not qualify himself to vote in the new precinct by notifying the Board of change of address, he will have lost his privilege of voting on May 8.

**Suppose he moves his residence on March 27?**

He will have been in the new precinct for 40 days by Election Day and, therefore, may register immediately.

**If a citizen in a registration district will reach his 21st birthday between March 28 and Novem-**




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ber 6 (date of the General Election), may he register?

Yes, he may register on or before March 28 and vote for candidates in the Primary Elections.

If a person who resides in a non-registration area will be 21 years old on or before November 6, what is the procedure?

If he meets other requirements of a voter, he will automatically become eligible to vote for candidates in the Primaries.

Where does one register?

At the headquarters of the Board of Elections of county of residence or at polling places indicated by the Board.

Where does a student register?

In most cases in the county in which he maintained residence just prior to entering the institution of learning.

How does a disabled person register?

A voter who is prevented by sickness or physical disability from registering in person may apply to his county Board of Elections by mail or phone for registration forms. The application must state the facts as to the voter's disability. Both the registration forms and a declaration of the facts as to disabiliy must be notarized, and both must be delivered to the Board of Elections by a reliable and responsible person. Some boards require this person to be a notary public.

What about persons in the armed forces?

Persons who are residents of a registration district and who are in active service in the armed forces, and are otherwise qualified to vote, may cast absentee ballots without previous registration. This regulation also applies to the spouse of a service member who is away from Ohio for the purpose of being with or near the service member.

Does this privilege extend to civilians who will be away from home on May 8?

No. Students and other persons who must be registered in order to vote and who plan to be away on May 8 should register now so that they will be eligible to cast absentee ballots.

### Absentee Voting

Persons who will be away from home on May 8 should plan to cast absentee votes. Here are some dates to remember and other data on absentee voting:

Civilians who wish to cast absentee ballots must be qualified to vote the same as though they were voting at home; e. g., they must be registered if they live within a registration area.

Civilians must apply for ballots on forms furnished by election boards. Upon receipt of filled out applications, boards will mail ballots which are to be properly filled out and returned in accompanying "identification" envelopes.

Ohioans who will be more than 10 miles from their polling places and outside their home counties on election day are eligible for absentee voter ballots.

Applicants for primary ballots must designate their party affiliation. Otherwise, there is no way to tell whether they should receive ballots listing Democrats or Republican candidates.

March 9 — First day for civilians outside the continental limits of the United States to apply for absent voter ballots.

March 28 — Last day for persons who must register in order to qualify for voting, to register with their local Board of Elections.

April 8 — First day for absent and disabled voters within the United States to apply for ballots.

May 3 — Last day for "absent or disabled" civilians to apply. The deadline is 4 p. m.

May 4 — Last day for civilians to return voted ballots to election boards to have them count. The deadline is noon of that day. Military personnel (and spouses who are out of Ohio for purpose of being with or near service members) have until noon of election day, May 8.

May 5 — Last day for members of the armed services to apply for ballots. Their deadline is 12 noon. Military service personnel have been eligible to apply for ballots since January 1.




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# Do You Know? . . .

Dr. Dwight M. Palmer, Columbus, has been named to the five-member advisory council to the Ohio Division of Mental Hygiene, it was announced by Dr. Robert Haines, director of the Department of Mental Hygiene and Correction. Dr. Palmer is chairman of the Ohio State Medical Association's Committee on Mental Hygiene.

* * *

Dr. Edmond K. Yantes, Wilmington, has been reappointed to the State Welfare Board for a term ending January 5, 1966. Dr. Yantes is a member of the Ohio State Medical Association's Committee on Care of the Aged.

* * *

The Ohio Public Health Council has scheduled a public hearing for 10:00 a. m. on Thursday, April 12 on regulations for nursing and rest homes, it was announced by Dr. Ralph E. Dwork, director of the Ohio Department of Health.

* * *

George H. Saville, Director of Public Relations, Ohio State Medical Association, participated in a panel discussion of how Tuberculosis and Health Associations look from the outside, at a state-wide conference of workers in that field sponsored by the Ohio Tuberculosis and Health Association, January 31 at Columbus.

* * *

Dr. George A. Woodhouse, Pleasant Hill, chairman of the Judicial Council of the American Medical Association, took part in a panel discussion at the recent Annual Congress on Medical Education, Chicago, on the subject, "Relationship of Grievance Committees and State Boards of Medical Examiners."

* * *

Theodore Wiprud, executive director for many years of the Medical Society of the District of Columbia, and well known in medical organization work, has announced his retirement effective July 1, 1962. George W. Cooley, Chicago, secretary of the AMA Council on Medical Services, and formerly executive secretary of the Academy of Medicine of Toledo, has accepted appointment to succeed him.

* * *

Richard S. Bachman, for the past 10 years executive director of the Ohio Citizens Council for Health and Welfare, Columbus, has been named executive director of the Welfare Council of Metropolitan Chicago.

* * *

Dr. Walter E. Vest, Editor of the *West Virginia Medical Journal,* died in Huntington on January 28. In addition to his many years of service to his state publication, Dr. Vest was active in the national conferences of medical editors and served for many years on the Advisory Council to the State Medical Journal Advertising Bureau.


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Obituaries

# Ad Astra

**Harry Lester Bard,** M. D., Cleveland; Western Reserve University School of Medicine, 1913; aged 79; died January 29. A native of Poland, and resident of this country for most of his life, Dr. Bard formerly practiced in the Cleveland area.

**George Warren Beers,** M. D., Albuquerque, New Mexico, Stritch School of Medicine of Loyola University, 1939; aged 50; died December 7; former member of the Ohio State Medical Association. Dr. Beers practiced in East Sparta and Canton from 1939 to 1942, at which time he entered the military service. After four years in service he took residency training in anesthesiology and moved to New Mexico. He had been in ill health since 1953. Surviving are his widow and a daughter.

**Harold D. Bockoven,** M. D., Dayton; Rush Medical College, 1934; aged 53; died January 16; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Ophthalmology. Dr. Bockoven's practice in Dayton extended over a period of about 20 years. He formerly was in Verona. Affiliations included memberships in the Methodist Church, several Masonic bodies and the Kiwanis Club. Surviving are his widow, a son, a daughter and a sister.

**Harry Gordon Clark,** M. D., Gallipolis; University of Toronto Faculty of Medicine, 1921; aged 63; died January 20. A native of Canada and a former resident of Birmingham, Mich., Dr. Clark had been a staff physician at the Gallipolis State Institute for about two years. Surviving are his widow and four children, all of Birmingham, Mich.

**Louis John Crum,** M. D., Cincinnati; University of Cincinnati College of Medicine, 1935; aged 53; died January 5 as the result of an injury; former member of the Ohio State Medical Association and the American Medical Association. Dr. Crum was a native of Cincinnati and served all of his professional career there with the exception of professional training abroad and service in the Army Medical Corps during World War II. He was a member of the Masonic Lodge and several other fraternal groups. Survivors include his widow, a daughter, a son, his mother and a brother, Dr. A. Harry Crum, also of Cincinnati.

**Edward Darwin Dowds,** M. D., Shelby; Western Reserve University School of Medicine, 1916; aged 70; died January 9; member of the Ohio State Medical Association and the American Medical Association. A native of Knox County, Dr. Dowds moved to Shelby in 1920 shortly after serving in the Army Medical Corps during World War I. Active in many community enterprises, he was for 37 years a member of the County School Board. Surviving are his widow, two daughters, two sons and two sisters.

**Martin Henry Fischer,** M. D., Cincinnati; Rush Medical College, 1901; aged 82; died January 20; member of the Ohio State Medical Association, the American Medical Association, American Physiological Society, American Chemical Society, American Association for the Advancement of Science, and many other professional organizations. A member of the faculty at the University of Cincinnati and director of the Department of Physiology for more than 40 years, Dr. Fischer was widely known as a man of science, art and letters. He was author of several medical texts, among them his textbook on physiology of alimentation and his work on edema and nephritis. His contributions to the scientific section of *The Journal* as to other publications were many. In the field of literature are his translations of one of Gracian's works and his books on the lives of Christian R. Holmes and William B. Wherry. His works of art have been exhibited throughout the nation and awards by colleges and professional organizations are too numerous to present here. A volume *Fischerisms* by two of his former students is now in its fifth edition. A physiology lecture room at the University of Cincinnati is dedicated to the memory of Dr. Fischer and is the gift of his late wife. Three nephews survive.

**William Clarke Hartland,** M. D., Chardon; State University of Iowa College of Medicine, 1930; aged 59; died January 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Hartland was health commissioner for Geauga County. Prior to accepting that post about two years ago, he was on the staff of the Huron Road Hospital, Cleveland. A native of Youngstown, he was a veteran of World War II, having served in the Army Air Corps Medical service. Affiliations included memberships in the Presbyterian Church and several Masonic bodies. Surviving are his widow, two brothers and a sister.

**Roger Hoffman McCaughtry,** M. D., Cortland and Warren; Ohio State University College of Medicine, 1925; aged 68; died January 17; member of the Ohio State Medical Association and the American Medical Association. A life resident of Trumbull County, Dr. McCaughtry served all of his professional

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career there, where he was a past-president and former secretary of the Trumbull County Medical Society. A veteran of World War I, he was a member of the Unitarian Fellowship. Survivors include his widow, a son, two brothers and two sisters.

**Levi Walter Naus,** M. D., Upper Sandusky; Eclectic Medical College, Cincinnati, 1899; aged 87; died January 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Naus practiced for more than a half century in the Upper Sandusky area and was a former Wyandot County coroner and health commissioner. A veteran of World War I, he was a member of the Masonic Lodge and the Baptist Church. Surviving are his widow, two sons and a sister.

**Edmond Henry Niesen, Sr.,** M. D., Cincinnati; Marquette University School of Medicine, 1915; aged 72; died January 14; member of the Ohio State Medical Association and the American Medical Association. A practicing physician of long standing in Cincinnati, Dr. Niesen was formerly director of the obstetrical department at St. Mary Hospital. Among affiliations, he was a member of the Catholic Church and the Knights of Columbus. Surviving are his widow; two sons, Dr. Edmond H. Niesen, Jr., also of Cincinnati, and Dr. Frank J. Niesen, St. Louis; also two sisters and three brothers, among them Dr. Leonard Niesen, Hudson, N. Y.

**Charles Cornelius Shearer,** M. D., Toledo; University of Cincinnati College of Medicine, 1916; aged 78; died January 5; member of the Ohio State Medical Association and the American Medical Association. A native of Saginaw, Mich., Dr. Shearer practiced for some 43 years in Toledo. He was a veteran of World War I, having served with the Army Medical Corps. Surviving are his widow, three daughters and a sister.

**Albert LeRoy Test,** M. D., Portsmouth; Hospital College of Medicine, Louisville, 1897; aged 97; died January 11; member of the Ohio State Medical Association and the American Medical Association. A native of Mt. Orab, Dr. Test moved to Portsmouth in 1902 a few years after receiving his medical degree. He was a member of the Methodist Church and the Masonic Lodge. Nieces and nephews survive.

**Fred Lawrence Watson,** M. D., Conneaut; Cleveland-Pulte Medical College, 1899; aged 87; died January 19. Dr. Watson practiced for more than 60 years in the Conneaut community before his retirement. He was a member of the Methodist Church, Woodmen of the World and Modern Woodmen of America organizations. A son and a daughter survive.

**John Gardner Weeks,** M. D., Ann Arbor, Mich.; University of Pennsylvania School of Medicine, 1958; aged 28; died January 31 in a traffic accident. A native of Ohio, Dr. Weeks took his internship at University Hospitals, Cleveland, and was in residency training in radiology at the University of Michigan. He was part of a large medical family related by either birth or marriage to a number of physicians in Ohio and neighboring states. His grandfather was Dr. Laferty McCuskey, late of Moundsville, W. Va. Dr. Merritt C. McCuskey, of Cambridge, is an uncle. Also surviving are his widow, three sons, his parents of Lakewood, a brother and both grandmothers. His wife and two sons were injured in the accident.

**Alven M. Weil,** M. D., Akron; University of Chicago School of Medicine, 1932; aged 57; died January 21; member of the Ohio State Medical Association, the American Medical Association, American College of Obstetricians and Gynecologists, International College of Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. Dr. Weil's practice in Akron dates back to 1935. In addition to his professional affiliations, he was a member of Temple Israel, Akron City Club, and the International Torch Club. During World War II he served with the Medical Corps and attained the rank of lieutenant colonel. Surviving are his widow, a son, a daughter and two brothers.

**Julian Vern Winans,** M. D., Madison; Eclectic Medical College, Cincinnati, 1888; aged 96; died January 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Winans practiced for more than 67 years in the Madison community, with time out for two terms in the Ohio Legislature and one in the Senate; also for service in the Medical Corps during World War I. In the Lake County Medical Society he held many offices including several terms as president; also he was a former county coroner. One of the few 75-year members of the Blue Lodge, he was affiliated with several other Masonic bodies, and was a member of the American Legion and Congregational Church. Two daughters survive.

**George Bela Zaboji,** M. D., Greentown; University of Budapest, 1933; aged 54; died January 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Zaboji was a native of Hungary and educated in Europe. He took residency training at City Hospital, Hartford, Conn., after coming to this country and was licensed in Ohio in 1958. He had been practicing in Greentown since 1959. Surviving are his widow and two sons.

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An optometrist has been appointed to the advisory committee to Selective Service on conscription of doctors and paramedical personnel. Dr. Princhas DeVere of Morgantown, North Carolina, has joined the group which now includes seven doctors of medicine, three dentists and one optometrist.

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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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## "Freedom Team" at Work In Mahoning County

The Mahoning County Medical Society has organized a "Freedom Team" for the purpose of combating the King-Anderson Bill and any other socialistic legislation.

The team, organized by Dr. John J. McDonough and Dr. Jack Schreiber, consists of twenty-three physicians, each of whom is prepared to speak to any organization concerning current legislation. Each speaker, equipped with a speaker's kit supplied by the Ohio State Medical Association, has prepared his own talk on the subject.

Information concerning the "Freedom Team" was put out through the Chamber of Commerce, service clubs, church organizations, and the *Youngstown Vindicator*. As a result, calls for speakers are coming into the medical society office. Many of these calls are from older age groups of people who want to know about medical care for the aged.

Once the request has been made, one of the team is assigned as a speaker. With twenty-three speakers to choose from, there is no difficulty in finding one available for almost any hour in the day.

Other activities of the "Freedom Team" will be the use of newspaper ads and radio spots prepared by the AMA. The team also answers any adverse editorials or letters to the editor, in an attempt to tell medicine's story to the people.

The team, originally set-up to include twenty physicians, has continued to grow as others volunteered their efforts. The current speakers include: Dr. John J. McDonough, Dr. Jack Schreiber, Dr. C. W. Stertzbach, Dr. W. H. Bunn, Jr., Dr. F. A. Resch, Dr. C. E. Pichette, Dr. F. L. Schellhase, Dr. R. A. Wiltsie, Dr. F. W. Morrison, Dr. K. E. Camp, Dr. Louis Bloomberg, Dr. J. F. Stotler, Dr. G. G. Nelson, Dr. Frank Gelbman, Dr. H. A. Smith, Dr. R. D. Murray, Dr. G. H. Dietz, Dr. H. L. Shorr, Dr. C. K. Walter, Dr. S. F. Gaylord, Dr. B. C. Berg, Dr. A. K. Phillips, and Dr. S. W. Chaisson.

## Sauvage, So-Called Hypnotist, Is Not Licensed, Board Says

Dr. H. M. Platter, secretary of the State Medical Board, has requested *The Journal* to advise physicians that John G. Sauvage, Syracuse, Meigs County, is not licensed by the State of Ohio to engage in the practice of medicine or any of its branches.

Sauvage, an employee of the State Highway Department, has been representing himself as being qualified to give instruction in hypnotism and to treat by hypnosis. Letters by him have been received by many physicians in Southern Ohio asking them to refer patients to him for treatment by hypnosis.

Sauvage will be prosecuted for violation of the Medical Practice Act unless he discontinues his representations and practices, which he has promised to do.


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Surgery of the Neck, March 15 - 17
Surgery of the Newborn, April 5 - 7
The Problems of Aging, April 26 - 28
Fluids & Electrolytes in Surgery, June 21 - 23
Pediatrics, July 26 - 28
Skin Grafting and Plastic Repairs, September 20 - 22
Clinical Endocrinology, October 25 - 27
Newer Surgical Procedures, December 20 - 22.

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## Cleveland Academy Invites Guests To Program on Health Costs

All members of the Ohio State Medical Association are invited to attend a special program of the Academy of Medicine of Cleveland and Cuyahoga County on Wednesday, March 28, on the subject, "Health Care and Costs — the Doctors Respond."

Social hour begins at 5:30 p. m. followed by dinner. Reservations for dinner should be sent by March 23 to the Academy office, 10525 Carnegie Ave., Cleveland 6, Ohio. Dinner reservations are $4.50. Dinner and meeting place are the Academy headquarters.

Beginning at 8:00 p. m., Dr. John R. Reed, chairman of the Education and Scientific Work Committee, will present findings of the physicians' discussion groups as compiled and summarized with the cooperation of the Executive Committee. This report will cover three main points: (1) What physicians already are doing to help control medical costs; (2) What needs to be done, and (3) What can be done.

---

## How To Deduct Cigarette, Liquor Tax on Federal Returns

Mr. P. L. Charles, Director, Cincinnati District, Internal Revenue Service, announced that taxpayers who itemize their deductions on their federal income tax returns may use the following guidelines in making any deductions for Ohio state taxes on cigarettes, wine, beer and liquor:

**Cigarette Tax, effective August 17, 1961:** Pack of 20 — 5c

**Liquor Tax, effective October 25, 1961**

Spirituous Liquor — 20c per 1/5th gallon.

Wine, 7% to 14% alcohol — 12c per gallon.

Wine, more than 14% to 21% alcohol — 30c per gallon.

Vermouth — 60c per gallon.

Sparkling & carbonated wine, champagne — $1.00 per gallon.

Mixed drinks—40c per gallon (prepared and bottled highballs, cocktails, cordials, and other mixed beverages).

Brewers Wort — 10c on each gallon or fraction thereof.

Brewers Malt — 3c on each pound or fraction thereof.

Bottled Beverages (Beer)—¾c on each 6 ounces or fraction thereof (3.2% alcohol or less and 3.2% to 7% alcohol).

Barrel Beer — $2.50 on each barrel of 31 gallons (3.2% alcohol or less and 3.2% to 7% alcohol).


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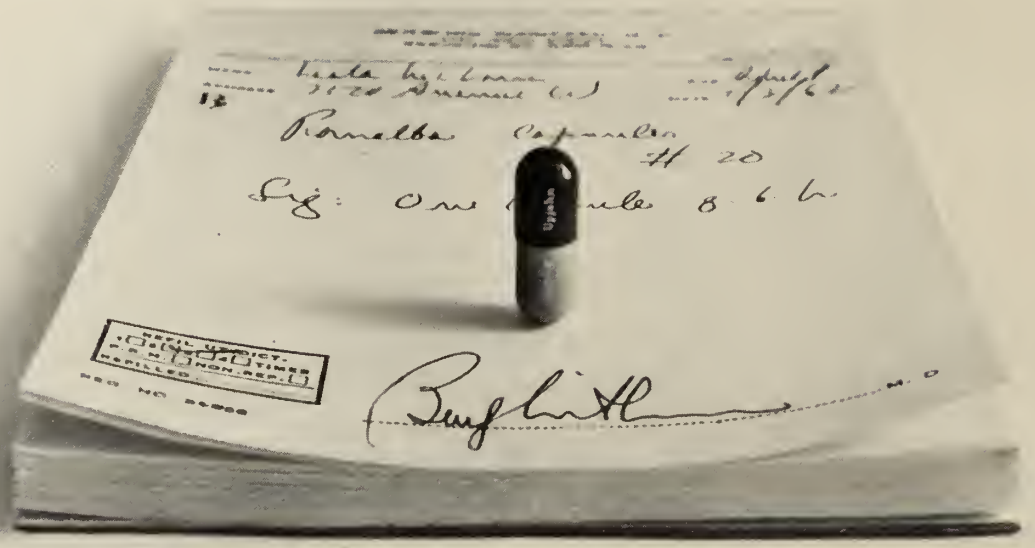


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*Supplied:* Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

*Usual Adult Dosage:* 1 or 2 capsules three or four times a day.

*Side Effects:* Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

*Warning:* Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

*TRADEMARK, REG. U. S. PAT. OFF.

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DECEMBER, 1961

## What To Write For

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* * *

**Some Facts About Suicide.** Discusses facts and fallacies, types of suicides, suicide attempts, crises. Write Publications and Reports Section, National Institute of Mental Health, Bethesda 14, Maryland.

* * *

**What Is a Gynecologist?** For patients. Helps women and their families understand services of and need for a gynecologist. Write American College of Obstetricians and Gynecologists, 79 West Monroe Street, Chicago 3, Illinois.

* * *

**Mental Illness Among Older Americans.** Prepared for consideration of the Special Committee on Aging, United States Senate. Asks consideration of a large-scale Federal grant-in-aid program for the States. (15 cents) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

* * *

**Medical School Facilities: Planning Considerations and Architectural Guide.** Prepared for use in planning establishment of new medical schools. Write Division of Hospital and Medical Facilities, Public Health Service, Washington, D. C.

* * *

**Health Information Foundation List of Publications.** Lists HIF research reports, inventories of health services, and other publications by the foundation. Write Health Information Foundation, 420 Lexington Avenue, New York 17, N. Y.

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## Blue Shield Payments for Period Reach an All-Time High

More than $613,600,000 was paid out by the 75 Blue Shield Plans located in North America for surgical-medical care rendered members during the first nine months of 1961, John W. Castellucci, executive vice-president of the National Association of Blue Shield Plans, reported.

The $613,651,525 represented an all-time high for a nine month period, and exceeded the 1960 figure for a comparable period by more than $62,000,000.

# Activities of County Societies...

## First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

### HAMILTON

The Academy of Medicine of Cincinnati in cooperation with the Heart Association of Greater Cincinnati sponsored a program on January 16 on the subject, "The Story of Patent Ductus Arteriosus: Review and Analysis of 600 Cases." Guest speaker was Dr. Willis J. Potts, professor of surgery at Northwestern University Medical School.

A number of specialty societies also held meetings during the month.

### WARREN

Dr. Ray E. Simendinger of Lebanon has been re-elected president of the Warren County Medical Society for another year.

Other officers re-elected include Dr. Dale E. Hubbard, Franklin, vice-president; Dr. D. P. Ward, Pleasant Plain, secretary, and Dr. Howard Berninger, Lebanon, treasurer.

Dr. Thomas E. Fox of Mason was named a delegate to the Ohio State Medical Association meeting with Dr. Orville Layman, Franklin, alternate. Dr. James H. Arnold, Lebanon, was named chairman of the legislative committee. The Board of Censors includes Dr. Frank Batsche, Mason, Dr. John Sharts, Franklin, and Dr. Simendinger. — *Middletown Journal.*

## Second District

(COUNCILOR: RAY M. TURNER, M. D., SPRINGFIELD)

### CHAMPAIGN

Dr. V. R. Frederick, Urbana, has assumed the presidency of the Champaign County Medical Society for this year.

Other officers named are Dr. T. E. Richards, president-elect; Dr. M. J. Towle, secretary-treasurer; Dr. I. Miller, delegate to the Ohio State Medical Association; and Dr. Fred Denkewalter, alternate delegate.—*Springfield News.*

### CLARK

The chief of surgical service at Columbus Children's Hospital, Dr. H. William Clatworthy, Jr., spoke to the January 15 meeting of the Clark County Medical Society. Dr. Clatworthy's topic was "Tumors in Children."—*Springfield News-Sun.*

### DARKE

Dr. Joel Webster of the cardiopulmonary laboratory of the Miami Valley Hospital at Dayton spoke to the January 16 meeting of the Darke County Medical Sociey on the topic "Retrograde Aortography."

### GREENE

Dr. Martin J. Cook, Springfield opthalmologist, spoke before the Greene County Medical Society on January 11 concerning "Corneal Transplanation" and "Eye Banks." Procedures and techniques were illustrated by colored slides.

New committees were appointed at the business meeting conducted by Dr. Alvin B. Salisbury, Fairborn, 1962 president. — *Xenia Daily.*

### MIAMI

Dr. Douglas Talbott of Dayton spoke to the January 9 meeting of the Miami County Medical Society on the subject of Coronary Heart Disease.—*Piqua Daily Call.*

### MONTGOMERY

Dr. Robert C. Austin, Dayton surgeon, and Dr. Wallace E. Prugh, retired general practitioner, were awarded "distinguished medical citizenship" citations for "outstanding service to the community in civic and medical affairs" at the inaugural dinner of the Montgomery Medical Society on January 12.

Dr. W. J. Lewis, founder and director of the Montgomery County Medical Society glee club, also was honored. He was presented with a framed copy of a *Life* magazine photo of the glee club taken at the AMA inaugural last June.

Dr. Lynne E. Baker received the presidential gavel from Dr. Charles G. Lovingood, retiring president.

Other new officers installed were: president-elect, Dr. Robert M. Craig; vice-president, Dr. George Martin; secretary, Dr. George Garrison; treasurer, Dr. William G. Cassel; trustee, Dr. E. F. Damstra; delegate, Dr. Sylvan Weinberg; alternate, Dr. Marion Lingle.—*Dayton Journal Herald.*

## Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

### SENECA

Members of the Seneca County Medical Society and the County Bar Association attended a joint meeting, the first such gathering, on January 16.

The program consisted of two films, one on "The Medical Witness," and the other on an annual legal checkup. Dr. Robert Schwalenberg, medical society

*(Continued on Page 373)*



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ances are you'd try to make them very much like our new Vi-Daylin® Chewable with Entrapped Flavor. pped Flavor means a better tasting chewable children's multivitamin; one with no vitamin aftertaste. Here's 1. We coat all the vitamins in a digestible film that does not dissolve until it reaches the gastrointestinal tract. means that unpleasant strong vitamin tastes are not released in the mouth, but in the g-i tract where they nost quickly absorbed. 2. We make certain that every Vi-Daylin Chewable tablet tastes citrus sweet good to every patient, everytime; we coat the flavoring oils in each tablet in a water soluble film. This dissolves immediately in the mouth, releasing the full bouquet of our citrus-candy flavoring agents. Now know why little patients always taste the flavor, never the vitamins, when you prescribe Vi-Daylin Chewable. And the formula's all you'd expect, with reasonable amounts of A & D. test them yourself and you'll prescribe **VI-DAYLIN CHEWABLE** regularly and soon.

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**All Other Elements Remain at Their Previous Level.**

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| Vitamin A (3000 units) | 0.9 mg. |
| Thiamine Mononitrate | 1.5 mg. |
| Riboflavin | 1.2 mg. |
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| Nicotinamide | 10 mg. |
| Pyridoxine Hydrochloride | 1 mg. |

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VI-DAYLIN—Vitamins A, D, $B_1$, $B_2$, $B_6$, $B_{12}$, C, and Nicotinamide, Abbott

(Contd. from Page 370)

president, presided, and George Forrest, bar association president, commented on the films. — *Tiffin Advertiser Tribune.*

## Fourth District

(COUNCILOR: EDWIN R. MURBACH, M. D., ARCHBOLD)

### LUCAS

Dr. W. A. Blank has been elected president of the Academy of Medicine of Toledo and Lucas County. Other 1962 officers include: Dr. Max T. Schnitker, chairman of the Board of Trustees; Dr. J. I. Collins, president-elect; Dr. G. N. Bates, secretary; Dr. C. L. Felker, trustee and councilors Dr. E. F. Ockuly, Dr. Wm. G. Henry, Dr. E. F. Glow and Dr. T. S. Miller.

### PUTNAM

The February meeting of the Putnam County Medical Society was held at Ben & Bernie's Restaurant, Kalida, Tuesday, February 6.

Guest speaker was Dr. Clement E. Kelley, Roentgenologist of Lima Memorial Hospital.

Dr. Kelley gave a lecture on "Lesions of the Lungs and Colon." He showed an interesting and timely selection of common and rare lung conditions, including mycotic and cystic disease, rare tuberculous lesions, sarcoidosis and cancer.

Also shown were various benign and malignant lesions of the colon, shown by colored slides. — H. N. Trumbull, M. D.

## Fifth District

(COUNCILOR: HENRY A. CRAWFORD, M. D., CLEVELAND)

### CUYAHOGA

The Academy of Medicine of Cleveland's January 24 meeting was devoted to a panel discussion of "Health Care and Costs."

Moderator was Dr. Frank M. Barry, surgeon on the staff of University Hospitals and the School of Medicine at Western Reserve University.

Participants included Dr. Douglas D. Bond, dean of the School of Medicine, Nathan Cohen, dean of the School of Applied Social Sciences at WRU; Edward D. Coningh, chairman of the Health Council of the Welfare Federation.

Others were Dr. Charles L. Hudson, also on the Medical School faculty; Sidney Lewine, administrator of Mt. Sinai Hospital, and John Mannix, executive director of the Blue Cross of Northeast Ohio.

Charles E. O'Dell, director of the Older and Retired Workers Department of the UAW-CIO of Detroit, cited the difficulties older persons face in obaining adequate health care.

After this session, a series of group discussions were held in the various Cleveland hospitals during February. A summation of these meetings will be presented at the next regular meeting, March 28. —*The Cleveland Press.*

### LAKE

The Lake County Medical Society heard a discussion of the latest developments in the use of artificial organs in the human body at their January 4 meeting.

Dr. Willem J. Kolff, head of the Department of Artificial Organs of the Cleveland Clinic, spoke on "The Artificial Kidney — Indications for Its Use."

Dr. Kolff, a member of the Division of Research of the Cleveland Clinic Foundation, completed research on the artificial kidney in his native Holland in 1941.

Several years later he began experiments on the artificial heart which have led to a number of discoveries including the clinical applicaton of a membrane oxygenator which is used in open-heart surgery.

New Society officers assumed their duties at the meeting. Dr. M. E. Burnham, Painesville, is president; Dr. Harry A. Killian, Willoughby, vice-president; and Dr. J. G. McClelland, Painesville, secretary-treasurer. — *Willoughby News Herald.*

## Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

### COLUMBIANA

A mass immunization program with the Sabin oral polio vaccine is planned for spring by the Columbiana County Medical Society for all residents of the county from 2 to 50 years old.

Tentative plans for the program, similar to one undertaken by the Mahoning County Medical Society, were discussed at a meeting of the physician's group Tuesday night at the Hotel Wick at Lisbon.

Dr. Leonard Pritchard of Columbiana, past-president, has been named chairman of a committee to plan the immunization program.

The society indicated it hopes that vaccine can be obtained and arrangements made to administer the first distribution in March, followed by the second a month or six weeks later, and the third by the end of May.

The immunization is to be conducted on a nonprofit basis, with a charge of about 50 cents for each dosage to cover costs of the vaccine, supplies, equipment, paper cups and other needs. — *East Liverpool Review.*

### MAHONING

The Mahoning County Medical Society honored its retiring president, Dr. A. K. Phillips, with a plaque at the annual banquet held on January 20, in the Mural Room Ballroom.

New officers installed were: Dr. C. W. Stertzbach, president; Dr. Asher Randell, president-elect; Dr. C. E. Pichette, secretary; and Dr. H. P. McGregor, treasurer.

Dr. Stertzbach was presented a gavel of curley maple turned out in the workshop of Dr. A. E. Brant. Dr. John J. McDonough, retiring editor,

was presented a bound volume of the medical society's Bulletin.

One hundred and seventy members of the medical Society and the Corydon-Palmer Dental Society and their wives attended the dinner and dance. Special entertainment was provided by Billie Webb. Chairman and master of ceremonies was Dr. S. D. Goldberg.

In a brief business meeting, the medical society passed a resolution opposing H. R. 4222 and similar legislation.

* * *

The Mahoning County Medical Society and Youngstown University are the subject of an article in a recent issue of the national publication, *Medical Economics*.

In a story titled, "Culture Made to Order for M. D.s," the magazine examines the local physicians' seminar, a series of lectures on non-medical subjects, and suggests that it is a program which other medical communities should consider.

The series was organized in the Spring of 1961 as an experiment by Dr. Jack Schreiber of the medical society and Dr. Clair L. Worley and John P. Gillespie of Youngstown University. The success of the first venture prompted a second seminar, currently being conducted under the supervision of Dr. Worley and Dr. Frank Gelbman.

The magazine quotes Dr. Schreiber's reasons for organizing the seminar. He said, "Like a lot of our colleagues elsewhere, we regretted having been forced to narrow our study to the scientific. As far as the arts and humanities were concerned, we felt out in the cold. We needed enlightenment in these fields not only for our professional enhancement, but for our personal well-being."

The two-page article carries a picture of Schreiber, Worley, and Gillespie with Mrs. Christine R. Dykema, the first lecturer.

The current seminar meets each Thursday at 8:00 p. m. at St. Elizabeth Hospital Auditorium.

### SUMMIT

The Summit County Medical Society met on February 6 in Akron. The program for the evening consisted of a panel discussion concerning "Relations of Physicians and Local Hospitals." Dr. W. A. Hoyt, Jr., served as moderator.

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

### BELMONT

Dr. William B. Kiesewetter, head of surgical service at the Pittsburgh Children's Hospital, was the guest speaker at the January 18 meeting of the Belmont County Medical Society.

*(Continued on Page 376)*

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(Contd from Page 374)

Dr. Kiesewetter spoke concerning "Tip-Offs to Trouble in the Newborn."

The Belmont County Medical Society met on February 15 with the Medical Society Auxiliary. The speaker for the evening was Dr. C. Merle Welch, Department of Anesthesiology, The Ohio State University. Dr. Welch spoke on the topic, "Respiratory Obstruction as a Problem of the General Physicians and Surgeons."

### JEFFERSON

Dr. Earl Rosenblum was elected president of the Jefferson County Medical Society. He succeeds Dr. Paul Mesaros. The election was held at the regular meeting in the Fort Steuben Hotel preceding the Ft. Steuben Academy meeting.

Dr. Carl Goll was elected president-elect; Dr. Paul Ruksha, secretary-treasurer, and Dr. Howard Brettell, censor.

Dr. Stanley Burkhardt was elected state representative to the Ohio State Medical Association convention. —*Steubenville Herald-Star.*

## Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, ZANESVILLE)

### PERRY

The Perry County Medical Society elected Dr. Michael Clouse, Somerset, president.—*Columbus Sunday Dispatch.*

## Ninth District

(COUNCILOR: CHESTER H. ALLEN, M. D., PORTSMOUTH)

### SCIOTO

Mr. Jay N. Cross, Portsmouth health commissioner, spoke before the January 6 meeting of the Scioto County Medical Society on the topic "A recent survey of polio immunization in Portsmouth."

## Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

### FRANKLIN

Mr. Gerard W. C. Fee, Reading Clerk of the Ohio House of Representatives, 104th General Assembly, spoke before the January 15 meeting of the Academy of Medicine of Columbus and Franklin County at the Fort Hayes Hotel. Mr. Fee's topic was "Whither Bound" (The Socialist Welfare State Design. Is this the blueprint for America?)

The business meeting featured the installation of the 1962 officers.

### PICKAWAY

Dr. F. W. Anderson was elected president of the Pickaway County Medical Society during its annual organizational meeting.

Other officers elected for 1962 terms were Dr. Carlos Alvarez, president-elect; Dr. E. L. Montgomery, secretary-treasurer; Dr. J. M. Hedges, delegate to the Ohio State Medical Association and Dr. Montgomery, alternate delegate.

New members of the Grievance Committee are Dr. H. H. Swope, Dr. Ray Carroll and Dr. Warren Hoffman. A public announcement of the committee's willingness to investigate and act on all grievances was made to Pickaway County residents.

Other committees appointed by the president were: School Health—Dr. Frank Moore and Dr. Swope; Rural Health—Dr. J. M. Hedges and Dr. R. S. Hosler; Maternal Health—Dr. Carroll and Dr. V. D. Kerns; Occupational Health—Dr. Kerns and Dr. Alvarez; American Medical Association Education and Research Foundation— Dr. Edwin Shane and Dr. Smith; Legislative Committee—Dr. Montgomery and Dr. Hedges;

District Medical Care—Dr. Walter Heine and Dr. Shane; Public Relations—Dr. Alvarez and Dr. Montgomery; Cancer Committee—Dr. Robert McCoy and Dr. Heine; Traffic Safety — Dr. Smith and Dr. Hoffman.—*The Circleville Herald.*

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### WAYNE

The week of January 22 was designated by Wayne County physicians and druggists as "Abolish Polio Week." Through arrangements made by the county medical society and the county pharmaceutical association, oral Sabin vaccine was offered to every person living there.

Each school child in the county was given a note to take home to parents explaining the plan briefly. Each child was then given a permission slip which had to be signed by a parent or guardian before the youngster was given the vaccine.

Beginning Monday, January 22 Wayne County health nurses, under direction of commissioner Dr. Lyman A. Adair, gave school children the vaccine during regular class hours.

On Wednesday, January 24, and on Saturday the 27th from 1-7 p. m., clinics were held in schools throughout Wayne County for adults and pre-school age children. A doctor, druggist and nurse were on hand at each of these clinics to answer questions and to supervise the clinic.

Those who could were asked to contribute 50 cents for each dose, but doctors and druggists emphasized that it was to be given free to any person or family if the funds were not available.—Adapted from *Wooster Daily Record.*

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U. S. Public Health Service is distributing $18,706,123 for research and research training programs among every medical, osteopathic and dental school in the nation. Medical grants range from $40,726 to $426,472, osteopathic from $29,080 to $48,550 and dental from $28,750 to $84,006.




Notice any change, Mrs. T.?" *"Well, Doctor... When I realized that I looked forward to teaching... really enjoyed being with the children again... I knew things were better..."* "Ever feel light-headed?" *"No... not at all. I feel perfectly normal now..."*

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# Activities of Woman's Auxiliary . . .

CHAIRMAN, PUBLICITY COMMITTEE — Mrs. F. M. Wadsworth, 35 Pinecrest, Mansfield, Ohio.
(Roster of Officers, Page 384)

### ALLEN

Forty-five Allen County doctors' wives met for dessert in January in the home of Mrs. W. G. Grannis. Assistant hostesses were Mrs. M. L. Lewis, Mrs. J. D. Hubbell, Mrs. R. J. Doernberg, Mrs. W. E. Yingling, Mrs. T. L. Edwards, Mrs. C. H. Zinsmeister, and Mrs. W. B. Light.

The program was in charge of the group's Mental Health Committee—Mrs. Nathan Kalb, chairman, Mrs. D. W. English, and Mrs. A. A. Dalton.

Mr. Calvin Workman, Director of Child Study and School Psychologist for the City of Lima, spoke on "Mental Health in the Public Schools."

His talk dealt with the school as a public institution, and concern with the mental health of the pupils, teachers, and other staff members of the institution. The aim is prevention rather than treatment of mental problems. In Lima, children who are felt to need help are referred to the Guidance Center or local professional medical men.

### CUYAHOGA

Mrs. J. Kenneth Potter, president, opened the new year with a continental breakfast on January 3. The regular monthly meeting of the Executive Board of the Woman's Auxiliary to the Academy of Medicine of Cleveland and Cuyahoga County followed. Board members and members at large were selected for the nominating committee. Health Career kits were assembled at this meeting to be distributed to the Vocational Guidance Counselors of all the High Schools in greater Cleveland. It was announced that the scheduled meeting on January 24 was to be a Fun-Day luncheon at the Cleveland Skating Club for a program of skating and curling.

Members have been collecting recent medical books which are now on their way to Liberia. A library is being established there for the use of medical missionaries. This is just part of a project under the auspices of Western Reserve University and many other interested organizations and individuals.

### HAMILTON

The Woman's Auxiliary to the Academy of Medicine of Cincinnati met for luncheon at the Hotel Sinton, on January 16, to hear Rabbi Albert Goldman, of the Isaac M. Wise Temple, discuss "The Meaning of Maturity."

Mrs. O. Herman Dreskin was in charge of the program with Mrs. Richard Salzer as her Vice-Chairman. Mrs. Donald Jacobs, Hospitality Chairman, was assisted by Mrs. Robert Price. Mrs. Richard Neubauer and Mrs. James Gray planned the decorations.

At the January meeting of the University of Cincinnati Woman's Auxiliary to the Student American Medical Association, Mrs. Carl F. Schilling, Auxiliary president, was the guest speaker. Her topic for discussion was "Medical Ethics for Doctors' Wives."

Volunteers from the Woman's Auxiliary have joined the City Health Department Volunteers, made up of representatives from other women's organizations, to assist in the Well Baby Clinics sponsored by the City Health Department. These volunteers, who will release registered nurses for professional duties elsewhere, will assume clerical duties, assist with patients, and disseminate good health information as patients wait. The Auxiliary volunteers, headed by Mrs. George Balz, who is representative to the Public Health Federation, met for the first time on January 29.

The Choral Group, accompanied by Mrs. Paul Foldes, gave a program on January 31, for the members and guests of the Mt. Auburn Music Club at the home of Mrs. John Marioni. This year marks the Tenth Anniversary of the Choral Group.

### HURON

Paramedical Careers Day which will be offered by Ohio State University to all interested students was the main topic of the afternoon when the Woman's Auxiliary to the Huron County Medical Society met for its January meeting.

Plans were made for local representatives of the Auxiliary to contact the various High Schools in the County. This will enable students interested in any one of the 11 vocations in the field of Paramedical Careers to avail themselves of the informative program to be held at Ohio State University in March. The dessert meeting was in the home of Mrs. Walter Drury in Willard.

### SCIOTO

The new home of Mrs. Robert N. Counts was the scene of the initial 1962 meeting of the Woman's Auxiliary to Scioto County Medical Society.

For the program, Mrs. Julian Smith presented a

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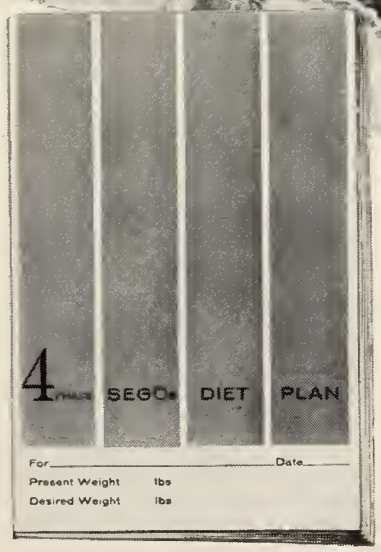
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series of colored slides of scenic places in European countries, which she and Dr. Smith took while they were living abroad with their children.

A business meeting was conducted by Mrs. Louis R. Chaboudy.

During the social hour, Mrs. Clyde M. Fitch presided at the refreshment table.

Those on the hostess committee assisting Mrs. Counts were Mrs. Fitch, Mrs. Joseph T. Gohmann, Mrs. Miller F. Toombs and Mrs. Carter L. Pitcher.

## Says Interns Must Know Their Stuff

By overruling a motion to certify the record, the Ohio Supreme Court let stand a verdict of $45,000 against Fairview Park Hospital, Cleveland (Larry Koubeck, appellee, v., Fairview Park Hospital, appellant, 35 Ohio Bar No. 2, Hospitals).

In refusing to review the negligence verdict against the hospital, the court in effect upheld the argument of the plaintiff's attorney that interns and residents working in a hospital emergency room must meet the standards of qualified physicians rather than be regarded as medical students. It was alleged that some of the trouble arose from the fact that the intern rendering the service did not understand or speak English well enough to carry on an intelligent conversation with the patient.

## Medical Alumni Reunion Scheduled at OSU

The Ohio State University College of Medicine will hold its annual alumni reunion Saturday, April 14, at the Ohio Union. Alpha Omega Alpha medical fraternity will sponsor breakfast for the alumni at 8:00 a. m., with Dr. William O. Robertson, associate professor of pediatrics at the University, speaking.

Registration will begin at 8:30 a. m. A scientific program beginning at 10 a. m. will precede the luncheon and afternoon reunion activities.

Speakers for the program and their topics are as follows:

Dr. Ray W. Gifford, Class of 1947, of the department of hypertension and renal disease at the Cleveland Clinic, "The Use and Misuse of Drugs in the Treatment of Hypertension."

Dr. Donald J. Holmes, Class of 1952, assistant professor of psychiatry at the University of Michigan, "Adolescent Psychology — Some Relevance."

Dr. Samuel A. Marable, assistant professor in the department of surgery at The Ohio State University, "New Concepts in Vascular Surgery."

# New Members . . .

The following are the names of the new members of The Ohio State Medical Association since December 1, 1961. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Adams**
Gary J. Greenlee, Manchester

**Auglaize**
J. Richard Hurt, St. Marys

**Belmont**
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Luis A. Vazquez, St. Clairsville

**Clark**
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Russell C. Metzger, Springfield
Joel Vanderglas, Fairborn

**Columbiana**
Anthony Cancilla, East Liverpool
Nicholas Soldo, East Palestine

**Cuyahoga**
Edmund L. Kaminski, Cleveland
William T. Wilder, Cleveland

**Darke**
William S. Elliott, Greenville

**Defiance**
Carlos R. Diaz, Defiance

**Gallia**
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Elwin W. Midgley Gallipolis
Gerard J. Obert, Gallipolis
James B. Stanton, Gallipolis

**Geauga**
Jose Luis Becerra, Middlefield
Arturo Dimaculangan, Chesterland

**Greene**
Cary B. Gardner, Xenia

**Guernsey**
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Floyd Cohen, Cincinnati
Werner E. Donath, Cincinnati
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**Henry**
R. Daniel Rigal, Liberty Center

**Huron**
John E. Rosso, Willard
Harold D. Erlenbach, New London

**Lake**
J. Edward DeMarco, Willoughby
David L. Farrington, Painesville
A. P. Panagopoulos, Painesville
Juan C. Ruiz-Bueno, Eastlake
Nancy L. Tuttle, Painesville

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Gabriel Sabga, Elyria
Robert E. Schotz, Lorain

**Lucas**
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Everett C. Kasher, Toledo

**Mahoning**
Gust Boulis, Youngstown
Robert E. Hamlisch, Youngstown
Nicholas G. Kastellorios, Youngstown
Maurice Oudiz, Youngstown
Angelo Riberi, Youngstown

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**Montgomery**
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Kieve L. Shapiro, Northfield

**Wood**
Andrew Klepner, Luckey

The American Association for the Study of Headache, Annual Meeting, will be held at the Palmer House, Chicago, Saturday, June 23. Details may be obtained from the president, Dr. Bayard T. Horton, Mayo Clinic, Rochester, Minn.

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4. **Tables and Charts.** Tables and charts that can be set in type may be included, and there will be no charge for their reproduction.

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SUMMIT—Frank M. McDonald, President, 437 Ohio Building "B", Akron 8; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Bldg., Akron 8. 1st Tuesday, monthly.

TRUMBULL—Thomas E. Wilson, President, 438 N. Park Ave., Warren; Mrs. Kay Ticknor, Executive Secretary, P. O. Box 1328, Warren. 3rd Wednesday, monthly.

### SEVENTH DISTRICT

BELMONT—Fred W. Cook, President, 111 S. 4th St., Martins Ferry; Bertha M. Joseph, Secretary, 100 S. 4th St., Martins Ferry. 3rd Thursday, monthly.

CARROLL—Thomas J. Atchison, President, 292 E. Main St., Carrollton; Jack L. Maffett, Secretary, 24 2nd St., N.E., Carrollton. 1st Thursday, monthly.

COSHOCTON—N. Harry Carpenter, President, 713 Main St., Coshocton; Harold W. Lear, Secretary, 133 S. 4th St., Coshocton. 2nd Tuesday, monthly.

HARRISON—James Z. Scott, President, Main St., Box 512, Scio; George E. Henderson, Secretary, Main St., New Athens. Meetings held every three months.

JEFFERSON—Earl Rosenblum, President, 224 N. 4th St., Steubenville; Paul W. Ruksha, Secretary, 633 Lawson Ave., Steubenville. 2nd Tuesday, monthly.

MONROE—O. C. Jackson, President, Woodsfield; Byron Gillespie, Secretary, S. Main St., Woodsfield.

TUSCARAWAS—Eugene R. Hammersley, President, P.O. Box 355, Tuscarawas; Robert J. Kuba, Secretary, 319 Grant Ave., Dennison. 2nd Thursday, monthly.

### EIGHTH DISTRICT

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FAIRFIELD—Charles F. Clark, President, 214 Harmon Ave., Lancaster; Stephen R. Hodsden, Secretary, 1423 W. Market St., Baltimore. 2nd Tuesday, monthly.

GUERNSEY—Earl E. Conaway, President, 1198 Clark St., Cambridge; Darell J. Smith, Secretary, Rt. 3, Cambridge Medical Arts Bldg., Cambridge. 1st Thursday, monthly.

LICKING—Lawrence H. Miller, President, 205 S. Prospect St., Granville; James A. Quinn, Jr., Secretary, Newark Hospital, Newark. Last Tuesday, monthly.

## County Societies' Officers and Meeting Dates (Continued)

MORGAN—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta. Called Meetings.

MUSKINGUM—Rankin A. Nebinger, President, Third St., Roseville; Benjamin W. Gilliotte, Secretary, 821 Market St., Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, 510 West St., Caldwell; Edward G. Ditch, Secretary, 415 Main St., Caldwell. 1st Tuesday, monthly

PERRY—Sydney N. Lord, President, E. Main St., Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—Clarence E. Ash, President, Marietta Memorial Hospital, Marietta; Tuathal P. O'Maille, Secretary, Marietta Memorial Hospital, Marietta. 2nd Wednesday, monthly.

### NINTH DISTRICT

GALLIA—Norman W. Pinschmidt, President, The Gallipolis Clinic, Gallipolis; Thomas P. Price, Jr., Secretary, The Holzer Clinic, Gallipolis. Last Thursday, monthly.

HOCKING—John W. Doering, President, 42 N. Spring St., Logan; Howard M. Boocks, Secretary, Court House, Logan. Called meetings.

JACKSON—John M. Cook, President, Oak Hill Hospital, Oak Hill; Brinton J. Allison, Secretary, Court House, Jackson. Called meetings.

LAWRENCE—Ralph F. Massie, President, 408 Washington St., Ironton; George Newton Spears, Secretary, 2213 South Ninth St., Ironton. Called meetings.

MEIGS—Joseph J. Davis, President, 306 N. 2nd St., Middleport; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy. Called meetings.

PIKE—Robert M. Andre, President, Lake White, Rt. 2, Waverly; Kenneth Wilkinson, Secretary, 330 E. Main St., Waverly. 1st Tuesday, monthly.

SCIOTO—Spencer W. Miller, President, 1021 9th St., Portsmouth; William E. Daehler, Secretary, 1004 24th St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President and Secretary, McArthur.

### TENTH DISTRICT

DELAWARE—Don K. Michel, President, 98 W. William St., Delaware; Edward C. Jenkins, Secretary, 470 S. Sandusky St., Delaware. 3rd Tuesday, monthly.

FAYETTE—Ralph Gebhart, President, 414 E. Court St., Washington C. H.; William L. Wead, Secretary, 1005 E. Temple St., Washington C. H. Last Tuesday, monthly.

FRANKLIN—Richard L. Fulton, President, 1211 Dublin Rd., Columbus 12; Mr. William Webb, Jr., Executive Secretary, 79 E. State St., Columbus 15. 3rd Monday, monthly, except May, June, July and August.

KNOX—Delbert C. Schmidt, President, 205 East Chestnut St., Mt. Vernon; Richard L. Smythe, Secretary, Medical Arts Bldg., Mt. Vernon. Usually 1st Wednesday, monthly.

MADISON—Sol Maggied, President, 15 E. Pearl, West Jefferson; Charles Terrill Hay, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—William S. Deffinger, President, Marengo; Joseph P. Ingmire, 28 W. High St., Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Francis W. Anderson, President, 416 E. Main St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Swank, President, 172 E. Main St., Chillicothe; David McKell, Secretary, 60 Central Center, Chillicothe. 1st Thursday, monthly, except June, July and August.

UNION—Walter R. Burt, President, West State St., Milford Center; May B. Zaugg, Secretary, 130 N. Maple St., Marysville.

### ELEVENTH DISTRICT

ASHLAND—Paul J. Sauder, President, 1109 Eastern Ave., Ashland; William H. Rower, Secretary, 1060 Claremont Ave., Medical Arts Bldg., Ashland. 1st Friday, monthly.

ERIE—Carl R. Swanbeck, President, 1218 Cleveland Rd., Sandusky; Donald B. Cuthbertson, Secretary, 421 Wayne St., Sandusky. Alternately, 3rd Tuesday and Thursday, monthly.

HOLMES—Neven P. Stauffer, President, W. Adams St., Millersburg; Luther W. High, Secretary, 109 S. Clay St., Millersburg. 2nd Wednesday, monthly.

HURON—John V. Emery, President, Box 269, Willard; Nino M. Camardese, Secretary, 12 Benedict Ave., Norwalk. 2nd Wednesday, every other month.

LORAIN—Roy E. Hayes, President, Elyria Medical Arts Bldg., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 214 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Nevin J. M. Klotz, President, 162 Main St., Wadsworth; Leroy G. Dalheim, Secretary, 220 East Liberty St., Medina. 3rd Thursday, monthly, except July and August.

RICHLAND—C. Karl Kuehne, President, 480 Glessner Ave., Mansfield; Carroll E. Damron, Secretary, 30 S. Mulberry St., Mansfield. 3rd Thursday, monthly.

WAYNE—G. G. Stitzinger, President, 1800 Beall Ave., Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday, monthly.

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# Classified Advertisements

Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

**Physicians seeking locations in Ohio** are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

EXCELLENT OPPORTUNITY for anyone interested in General Practice in pleasant community of 1,000 population (40 miles northwest of Dayton); house-office combination with equipment; no other doctor in town; reasonable price. Available immediately. Box 199, c/o Ohio State Medical Journal.

OFFICE SPACE FOR RENT due to death of physician. Established practice for 40 years. Ten miles to Dayton or Middletown hospitals. Community 3000 population. Will rent or lease office completely furnished with all equipment. Patients records also available. Box 236, c/o Ohio State Medical Journal.

GENERAL PRACTITIONERS WANTED To serve four communities of 25,000 people, 15 miles west of Cleveland on the banks of Lake Erie. Population booming. Good schools, churches, shopping and recreational centers near area. Adequate housing available. Active and friendly medical staff and societies present. New modern 300 bed hospital 7 miles away; another similar one 15 miles away; and another 150 bed circular progressive-care hospital in blueprint stage after voters approved funds for its construction. Parties interested may be able to associate with or form partnerships with present practitioners. OFFICES AVAILABLE — New, modern, air-conditioned, 8-unit office building ready for occupancy in Fall 1961 — located on 8 acre parcel of land — 3 units available. Please write to John P. Jasko, M. D., 33201 Lake Road, Avon Lake, Ohio; Phone WEbster 3-5117.

FOR RENT: Office suite in new building, air-conditioned, on ground floor, ample parking. Located near hospital in community needing additional doctors. Reply Box 253, c/o Ohio State Medical Journal.

WANTED: Physician for Put-in-Bay, heart of Ohio's Lake Erie vacation area; Township owned office and residence rent free; also subsidy; Port Clinton hospital nearby; 700 permanent residents; 4000 summer season. For further information contact: F. Romer Stoiber, Township Clerk, Put-in-Bay, Ohio.

WANTED: General surgeon, Board certified or qualified, to join three man general practice group in northern Minnesota. Excellent hunting, fishing, and skiing in the area. Associated with large specialty group in nearby community. Very active practice with some industrial medicine. New hospital facility completed 1960. Unusually liberal partnership agreement. Contact Mr. Allen G. Farley, East Range Clinic, Virginia, Minnesota.

WANTED: Orthopedist to join 17-man Ohio Clinic with associated hospitals. Excellent professional and economic opportunity. Part-time teaching and research possible. Please apply promptly. Box 248, c/o Ohio State Medical Journal.

EXCELLENT COLUMBUS OPPORTUNITY: Location at 2675 W. Broad St., at present occupied by internist for 7 years; previously by general practitioner for 30 years; all private offices, private consultation room, business office, x-ray and three treatment rooms, plus large reception room. Excellent corner location. BR. 9-9401; after 6 p. m., BR. 9-2349.

PHYSICIAN WANTED To take over on rental basis a fully equipped recently deceased doctor's office in southwest Ohio community of 100,000. Records available. $125.00 per month, complete. Call Cincinnati PL 1-4392.

DOCTOR'S OFFICE AVAILABLE: 7 air conditioned rooms; new, formerly occupied by physician; next to drug store. Inquiries for future dates invited; ideal for single or dual practice. 18th and Oberlin Ave., Lorain, Ohio; Ph. CH 4-0633.

WANTED: Internist, Board eligible or Board certified to join 15 man Ohio Clinic. Excellent opportunity. New facilities. Fine hospitals. Near University. Good library and research facilities. Salary open. Box 257, c/o Ohio State Medical Journal.

OBSTETRICIAN or PEDIATRICIAN, CIN'TI, OHIO: Excellent opportunity in new medical center; No capital investment required; owner will remodel to suit; wood paneled waiting room, private office, receptionist area and examining rooms. Building also houses Medical Doctor, Medical Laboratory and Dentist Suites. June graduates invited to investigate. Wm. G. Menke, 2532 Indian Mound Ave., Cin'ti 12, Ohio.

WANTED: Excellent opportunity for general practitioner with or without surgical-orthopedic training for association in established industrial clinic in Northeastern Ohio. Guaranteed salary with percentage bonus. Partnership considered. Write stating qualifications. Box 256, c/o Ohio State Medical Journal.

WANTED Energetic Internist and General Practitioner to Supplement Aggressive Seven Doctor Team in Ultra-Modern Clinic, Affiliated and Attached to 100 Bed Hospital in Detroit. Unparalleled Opportunity for Professional Advancement and Personal Satisfaction. Most Attractive Financial Arrangements. Write Box 254, c/o Ohio State Medical Journal.

THREE FULL TIME HOUSE OFFICERS. 2 - 3 Years Previous Surgical Training Required. 100 Bed Acute Hospital. Unusual Opportunity to Work with Board Specialists. Highly Attractive Stipend and Working Hours. Write for Full Particulars to Box 255, c/o Ohio State Medical Journal.

ORTHOPEDIC SURGEON, Board Qualified; 33 years; interested in group practice or association in Ohio. Box 251, c/o Ohio State Medical Journal.

PICKER X-RAY - FLUOROSCOPE: Tilt table; 100 MA - 100 KV with all accessories. Michael Truman, M. D., 1070 Millville Ave., Hamilton, Ohio; 895-4541 or 895-9498.

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WANTED: Young ob-gyn. specialist, certified or qualified, to join two-man ob-gyn. partnership. Northern Ohio. Excellent office and hospital facilities. Box 264, c/o Ohio State Medical Journal.

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EXCELLENT OPPORTUNITY for Physician with experience in public health and administration, to fill a position of Health Commissioner of Geauga County. Living conditions exceptional. Position available immediately. Maximum salary, $12,000, with increases yearly, depending on performance. Write C. K. Adrian, M. D., Medical Arts Building, Chardon, Ohio.

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LUCRATIVE Small town general practice in suburban Cincinnati for sale, lease, or one year locum tenens. Leaving June 1, 1962, for postgraduate study. Box 242, c/o Ohio State Medical Journal.

PRACTICE ON THE SHORES OF LAKE ERIE Near Islands. Opportunity for young American-trained man with family who loves outdoors. Buy this equipment and General Practice (30% Anesthesia). Low rent. Collections excellent in this modestly thriving practice established 8½ years. Town of 6700 between Sandusky and Toledo, draws from densely populated rural and shoreline area of 15,000, growing all the time. Office personnel can remain. Hospital 3 minutes away. Available in June or July. Box 258, c/o Ohio State Medical Journal.

ORTHOPEDIC SURGEON: Competent qualified physician urgently needed as assistant in busy practice. Salary to start, $1,100 - $1,200 per month for physician not board eligible but interested in learning orthopedics, and $1,500 for orthopedic surgeon. Partnership or association at later date if mutually agreeable. Very large office has four examining rooms, complete x-ray, complete physiotherapy department with 6 aides including physiotherapists and/or nurse. Two hospitals within five minutes driving time. Box 260, c/o Ohio State Medical Journal.

*(More Classified Ads on Facing Page)*

## Classified Advertisements (Contd.)

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### OSU College of Medicine Sponsors Programs

The Ohio State University College of Medicine has announced the following programs sponsored March-May:

March 5 - 6 — Ophthalmology Course.

March 19 — Psychiatry Seminar.

March 21 — Recent Advances in Therapy of Heart Disease.

April 11 - 13 — Pediatrics — What's New in '62.

May 4 - 5 — Basic Science Conference in Orthopedics.

May 24 - 25 — Use of Radioisotopes in Kidney Disease.

# Coming Meetings . . .

**American Medical Association,** Annual Meeting, Chicago, June 24-28.

**Ohio State Medical Association,** Annual Meeting, Columbus, May 14-18.

**American College of Physicians,** 43rd Annual Session, Philadelphia, April 9-15.

**Frank E. Bunts Educational Institute,** Cleveland Clinic, Course in Liver Diseases, March 7 and 8.

**The George M. Curtis Lecture,** Ohio Union, Ohio State University April 23, 4:00 p. m., by Dr. Francis D. Moore, Moseley Professor of Surgery, Harvard Medical School.

**Ohio State Radiological Society** meeting, Akron, May 25-27, Chapin Hawley, M. D., Secretary, 927 Carew Tower, Cincinnati 2.

**Ohio State Surgical Association,** Annual Meeting, Nationwide Inn, Columbus, Friday, May 11.

**University of Cincinnati College of Medicine,** Annual Samuel Freedman Lecture in Diagnostic Radiology, April 28, 29.

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The Southwestern Ohio Society of General Physicians presented a seminar on Arthritis and Related Conditions in collaboration with the University of Cincinnati College of Medicine on February 11. Dates and subjects of coming programs may be obtained by contacting the program committee secretary, Dr. Kenneth A. Frederick, 5789 Colerain Ave., Cincinnati 39, Ohio.

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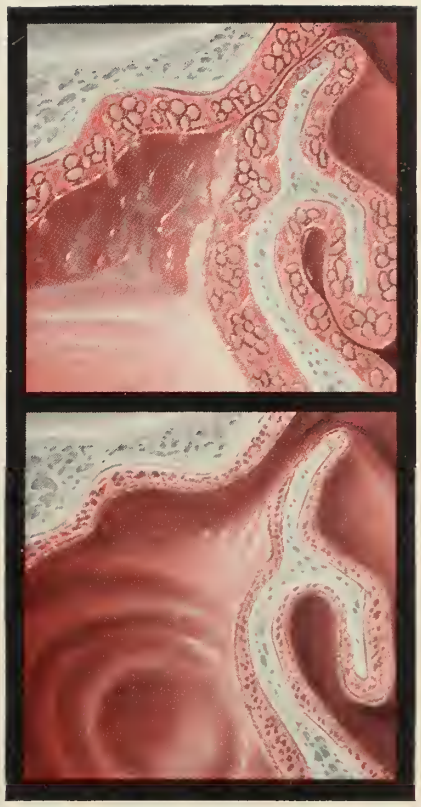
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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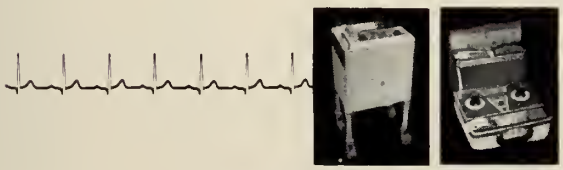
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## "nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

**cardiac diseases** "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

**arthritis** "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

**digestive diseases** Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25.673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

**degenerative diseases** "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

**infectious diseases** Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported In: Medical Science 8:772 (Dec.10) 1960.

**diabetes** Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . .There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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*Gamble, C.J.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960. See also Berberian, D.A., and Slighter, R.G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Kaufman, S.A.: Obst. and Gynec. *15*:401 (March) 1960; Warner, M.P.: J.Am.M. Women's A. *14*:412 (May) 1959.

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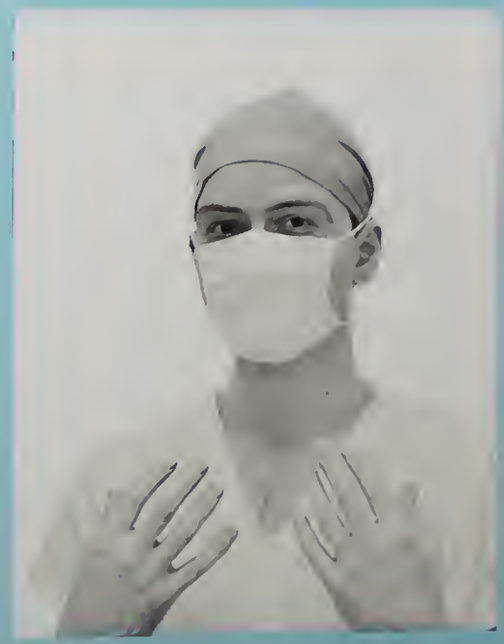
*(Questionnaire, The Maternal and Child Welfare Committee, South Dakota State M. A., 1958)*[1]

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*(Beck and Rosenthal, State University of New York)*[3]



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In one of the most commonly used technics, an initial dose of 100 mg. of Demerol and 1/150 grain of scopolamine is given intramuscularly when labor is established. Subsequently, 100 mg. of Demerol are given every four hours and 1/200 grain of scopolamine every three hours. "Within 15 or 20 minutes the pain is relieved and neither the frequency nor the intensity of the uterine contractions are diminished."

*(Beck and Rosenthal)*[3]

Demerol is "...an analgesic drug which relieves pain about as well as does morphine, and it has in addition an antispasmodic action which makes it a good preparation for use during labor.... It may be given alone but its effect is enhanced when it is used in combination with scopolamine, and the resultant amnesic effect is excellent."

*(Titus, Pittsburgh)*[5]

**SIDE EFFECTS AND CONTRAINDICATIONS:** Demerol hydrochloride is generally well tolerated and nontoxic in therapeutic doses. Side effects occur more frequently in ambulatory patients (who should therefore be specially cautioned) than in those confined to bed. Dizziness is the most common reaction. Nausea or vomiting occurs less frequently than after administration of morphine. Flushing of the face, sweating and dryness of the mouth are sometimes noted. More severe reactions are characterized by great weakness, syncope, profuse perspiration, marked dizziness, and nausea and vomiting. They usually can be prevented if the patient lies down promptly at the onset of side effects. Tolerance to side effects usually develops quickly if medication is continued in small doses (25 mg.). In contrast to morphine, respiratory depression occurs infrequently. However, in patients with lesions that cause increased intracranial pressure, respiratory depression has been noted; therefore, the drug is considered to be contraindicated in such persons.

When Demerol with Scopolamine is used, idiosyncrasy to scopolamine may be encountered occasionally, producing the paradoxic effect of excitement, restlessness, hallucinations and delirium instead of sedation and amnesia. In addition, edema of the uvula, glottis and lips may be encountered occasionally in extremely hypersensitive patients.

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1. Ranney, Brooks: *South Dakota J. Med. & Pharm.* 11:479, Dec., 1958.
2. Posner, L. B.; Fielding, W. L., and Posner, A. C.: *Obst. & Gynec.* 2:81, July, 1953.
3. Beck, A. C., and Rosenthal, A. H.: Obstetrical Practice, ed. 7, Baltimore, The Williams & Wilkins Company, 1958, pp. 1029, 1030.
4. Hershenson, B. B., and Reid, D. E.: *Bull. Narcotics* 8:36, July-Sept., 1956.
5. Titus, Paul: The Management of Obstetric Difficulties, ed. 5, St. Louis, C. V. Mosby Co., 1955, p. 617.


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Accompanying this year's edition is the following important notice from the American Medical Association:

"It has come to our attention that the inclusion of a drug in *New and Nonofficial Drugs,* published annually by the American Medical Association's Council on Drugs, is being misinterpreted by persons or organizations as a form of acceptance, approval, or endorsement, and that this inclusion has erroneously been used as a basis for authorization of purchases of hospital medications or allowance of hospital insurance payments for drugs. This misunderstanding undoubtedly stems from the former 'Seal of Acceptance Program,' under which the Council limited its descriptions of drugs to those considered to have well-established clinical usefulness. This 'Seal of Acceptance Program' was discontinued in 1955 in order to provide physicians with a service of much greater magnitude.

"The Council on Drugs does not conduct clinical tests or laboratory analyses of drug preparations, nor does it endeavor to compare the quality of various brands. Rather, the Council provides authoritative comment on the actions, indications, limitations, hazards, routes of administration, and dosages of drugs; its opinion is based on both published and unpublished reports. The Council also attempts to standardize nonproprietary nomenclature, and trademark names are included merely as a matter of information to aid in the recognition of drugs.

"The Council statements about the drugs included in *New and Nonofficial Drugs* are intended solely for the information and guidance of physicians. Many of these drugs are commented upon favorably, but other drugs are included solely for the purpose of advising physicians that the Council does not consider these drugs as suitable therapeutic agents on the basis of existing knowledge. Thus the mere fact that a drug is described in *New and Nonofficial Drugs* should never form the basis for its inclusion in a list of approved or accepted drugs, such as may be required in governmental or private insurance plans, in similar reimbursement plans, or in hospital formularies.

"On the other hand, the Council's evaluations of drugs in *New and Nonofficial Drugs* and in *The Journal of the American Medical Association* should be most useful to physicians responsible for compiling such lists of 'approved drugs.'"

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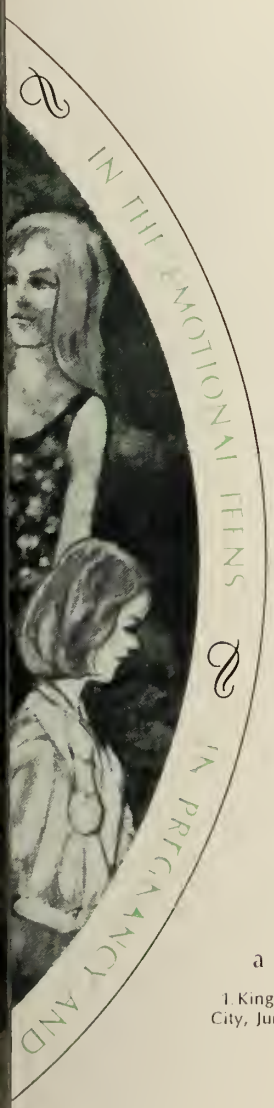

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*As You Like It, Act II, Sc. 7

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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VISTARIL acts rapidly in the symptomatic treatment of a variety of neuroses and other emotional disturbances manifested by anxiety, apprehension, or fear—whether occurring alone or complicating a physical illness. The versatility of VISTARIL in clinical indications is matched by wide patient range and a complete complement of dosage forms. The calmative effect of VISTARIL does not usually impair discrimination. No toxicity has been reported with the use of VISTARIL at the recommended dosage, and it has a remarkable record of freedom from adverse reactions.

**INDICATIONS:** VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

**ADMINISTRATION AND DOSAGE:** Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

**SIDE EFFECTS:** Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

**PRECAUTIONS:** Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

**SUPPLIED:** VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

*More detailed professional information available on request.*

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## American Heart Association's Fall Meeting To Be in Cleveland

The 1962 Annual Meeting and Scientific Sessions of the American Heart Association will be held in Cleveland from October 26-30. The Scientific Sessions are scheduled from Friday, October 26, through Sunday, October 28.

May 15 is the deadline for submitting abstracts of papers for presentation at the Scientific Sessions. Papers must be based on original investigations in, or related to, the cardiovascular field. Official forms for submitting abstracts may be obtained from Richard E. Hurley, M. D., Medical Associate, American Heart Association, 44 East 23rd Street, New York 10, New York.

Applications for scientific exhibit space are also available from Dr. Hurley. These must be returned not later than May 15, 1962.

## Pleasure Dollars Double Medical Dollars

The American public is spending nearly twice as much money for recreation, alcoholic beverages, and tobacco as it is for medical care, the Health Insurance Institute reports.

Out of every dollar the public spends, more than 11 cents goes for the combined costs of recreation (5.9 cents), alcohol (3.0), and tobacco (2.3), while 5.9 cents is spent for medical care, said the Institute in a report based on personal consumption expenditure figures compiled by the U. S. Department of Commerce.

These figures show that in 1960 Americans spent $329 billion on their personal needs. Of this total, $19.6 billion was spent on medical care.

Recreation expenditures amounted to $19.4 billion, $9.9 billion was spent on alcoholic beverages, and tobacco accounted for $7.5 billion, for a total of $36.8 billion on these three items, or 11.2 per cent of all personal consumption expenditures.

## Venereal Disease Abstracts Available on Request

Since 1957, infectious syphilis has been increasing at an alarming rate in all races, sexes, ages, social groups and geographic areas, the U. S. Public Health Service reports. To serve a pressing need, the Venereal Disease Program of the PHS is abstracting current literature on the subject and making this material available in a publication entitled "Current Literature on Venereal Disease." This abstract is published three or four times a year.

Physicians who wish to be placed on the mailing list should communicate with Communicable Disease Center, Atlanta, Atlanta 22, Georgia, Attention: Dr. William J. Brown, Chief, Venereal Disease Branch, giving the name of the publication.

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*"In a group of 100 patients, of whom 60 had diabetes, arteriosclerosis, hypertension, or a combination thereof, we were able to get weight reduction, using* (OBETROL) *and diet...With a daily divided dosage of 30 milligrams of* (OBETROL) *we were able to obtain appetite depression without nervous restlessness or insomnia..." 26 patients who previously had been unable to use other amphetamines in any dosage sufficient to maintain the anorectic effect, responded favorably on this medication.*[1]

**DIABETIC PATIENTS** on OBETROL showed improved carbohydrate *tolerance* with decreased need for hypoglycemic agents.[1]

**HYPERTENSIVE, ARTERIOSCLEROTIC AND CARDIOVASCULAR PATIENTS** on OBETROL showed: ■ no increase in angina or elevation of blood pressure... ■ diminished need for hypotensive agents, and nitroglycerine... ■ decreased evidence of coronary insufficiency.[1]

**PATIENTS REJECTED PLACEBO** – *"An attempt was made to use a placebo tablet identical in appearance in a group of 25 patients at the end of the 4th week of therapy. Not surprisingly, there was universal rebellion to the substitution and almost immediate demand for the active pill."*[1]

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REFER TO PDR

(1) Bernstein, A. & Simon, F. "The treatment of Obesity in patients with Cardiovascular Diseases" Presented at Am. Coll. of Angiology meeting; June 12, 1960.

(2) Plotz, M.: Modern Management of Obesity, J.A.M.A. 170:1513-1515 (July 25) 1959.

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ances are you'd try to make them very much like our new Vi-Daylin® Chewable with Entrapped Flavor. pped Flavor means a better tasting chewable children's multivitamin; one with no vitamin aftertaste. Here's 1. We coat all the vitamins in a digestible film that does not dissolve until it reaches the gastrointestinal tract. means that unpleasant strong vitamin tastes are not released in the mouth, but in the g-i tract where they nost quickly absorbed. 2. We make certain that every Vi-Daylin Chewable tablet tastes citrus sweet good to every patient, everytime; we coat the flavoring oils in each tablet in a water soluble film. This dissolves immediately in the mouth, releasing the full bouquet of our citrus-candy flavoring agents. Now know why little patients always taste the flavor, never the vitamins, when you prescribe Vi-Daylin Chewable. And the formula's all you'd expect, with reasonable amounts of A & D. test them yourself and you'll prescribe **VI-DAYLIN CHEWABLE** regularly and soon.

ABBOTT

lin–Vitamins A, D, $B_1$, $B_2$, $B_6$, $B_{12}$, C, and Nicotinamide, Abbott.

# Profile of a multivitamin




## New Vi-Daylin Chewable —with entrapped flavor

### New Formula

In recognition of recent medical thinking, we've reduced the vitamin D in our formula from 20 mcg. (800 units) to 10 mcg. (400 units). At the same time, we've increased the vitamin C content from 40 mg. to 50 mg. per tablet and per 5-cc. lemon-candy teaspoonful.

### All Other Elements Remain at Their Previous Level.

| | |
|---|---|
| Vitamin A (3000 units) | 0.9 mg. |
| Thiamine Mononitrate | 1.5 mg. |
| Riboflavin | 1.2 mg. |
| Cobalamin ($B_{12}$) | 3 mcg. |
| Nicotinamide | 10 mg. |
| Pyridoxine Hydrochloride | 1 mg. |

### New Low Price

In quantities of 100 tablets our new Chewable costs less than 4¢ a tablet and the normal dosage is one tablet daily. No financial hardship for your patients when you prescribe or recommend Vi-Daylin.

### New Shape, New Color, New Bottle

New Vi-Daylin Chewable tablets are football shaped. This shape got a high degree of acceptance in our taste-tests and seems to have an intrinsic interest for children. The orange color ties in with the mild, sweet citrus flavor. And the wide-mouthed new bottle looks handsome on the table.

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Won't you taste-test new Vi-Daylin Chewable multivitamins yourself? We're certain you'll be pleasantly surprised at their sweet good taste. They're the candy-flavored multivitamins with *entrapped flavor* . . . little folks taste the candy flavor, never the vitamins.

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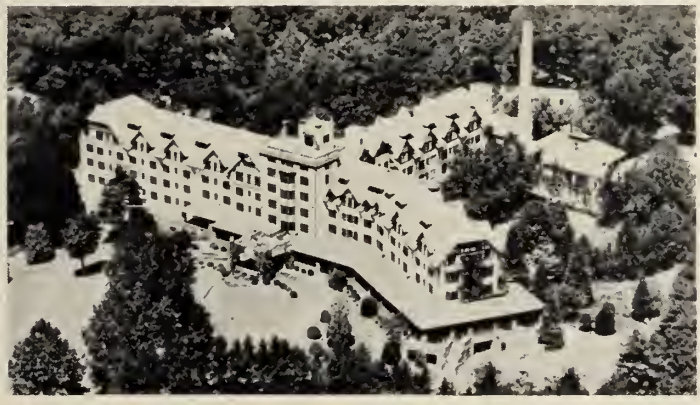
# Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

| Location | Facility | Telephone |
|---|---|---|
| Akron | Children's Hospital<br>W. Bowery and W. Bechtel | BL 3-5531, Ext. 246 |
| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
| Toledo | Toledo Health Department<br>635 N. Erie St. | CH 4-1961—(Day)<br>EV 5-4661—(Night) |
| Youngstown | Emergency Room Dept.<br>St. Elizabeth Hospital<br>1044 Belmont Street | RI 6-7231<br>Ext. 220 |


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| butabarbital sodium (Warning: may be habit-forming) 15 mg. (¼ gr.) | belladonna extract 10 mg. (⅙ gr.) | dehydrocholic acid, AMES 250 mg. (3¾ gr.) |

**Available:** Bottles of 100 tablets.

for **spasm** and **stasis**

**DECHOLIN® WITH BELLADONNA**

belladonna extract, 10 mg. (⅙ gr.)
dehydrocholic acid, AMES, 250 mg. (3¾ gr.)

for **stasis** alone

**DECHOLIN®**

dehydrocholic acid, AMES, 250 mg. (3¾ gr.)

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# LISTICA®

[1]Taub, S. J.: Management of Anxiety in Allergic Disorders—New Approach. To be published in Psychosomatics; [2]Cahn, B.: Experience with a New Tranquilizing Agent (Hydroxyphenamate). Ibid; [3]Bergal, M., Beck, C., Davis, O. F., and Sloan, N.: On Use of Hydroxyphenamate in Anxiety Associated with Somatic Disease. To be published; [4]Alexander, L.: Effect of Hydroxyphenamate on Conditional Psychogalvanic Reflex in Man. Supplement to Diseases of the Nervous System, Sept., 1961 [5]Cahn, B.: Effect of Hydroxyphenamate in Treatment of Mild and Moderate Anxiety States. Ibid; [6]Cahn, M. M., and Levy, E. J.: Use of Hydroxyphenamate (Listica) in Dermatological Therapy. Ibid. [7]Eisenberg, B. C.: Amelioration of Allergic Symptoms with a New Tranquilizer Drug (Listica). Ibid; [8]Friedman, A. P.: Pharmacological Approach to Treatment of Headache. Ibid; [9]Greenspan, E. B.: Use of Hydroxyphenamate in Some Forms of Cardiovascular Disease. Ibid; [10]Gouldman, C., Lunde, F., and Davis, J.: Clinical Trial of Hydroxyphenamate in Alcoholic Patients. Ibid. [11]Personal Communications to Medical Department, Armour Pharmaceutical Company.

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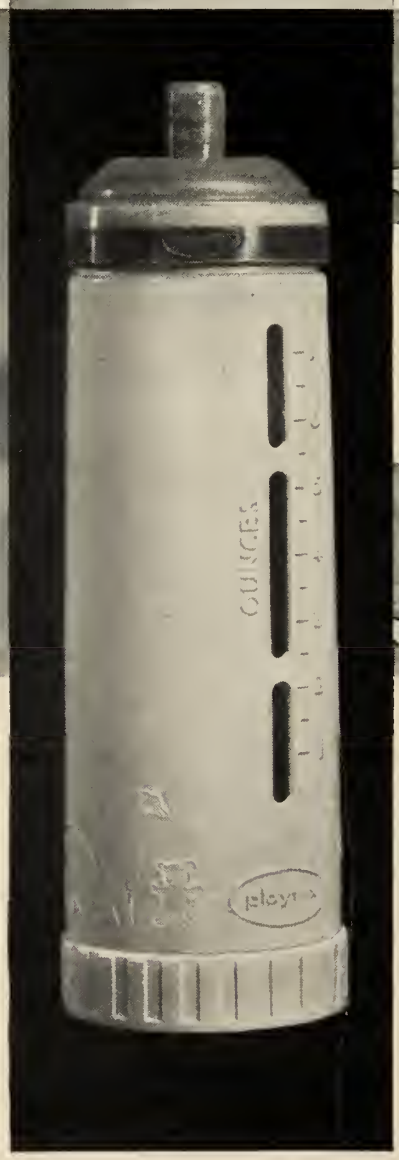
# The revolutionary discovery that simulates breast feeding.....

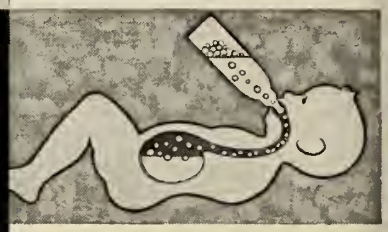


*Natural nursing action nipple induces even sucking that dramatically lessens outside air swallowing and makes baby exercise his jaws. Designed to avert tongue-thrusting and other malocclusions not inhibited by conventional nipples.*

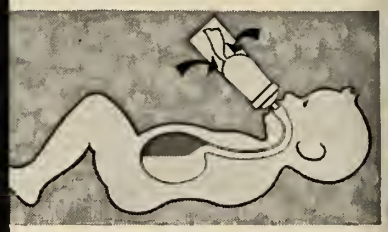


*Because the disposable bottle is pre-sterilized, it eliminates the possibility of contamination through improperly sterilized bottles.*



*With conventional bottle air has to get inside bottle for milk to come out. Nipple often collapses and baby has to suck harder, so more air gets into his stomach. Both overfeeding and underfeeding can ensue, along with the aerophagia and flatulence which can produce colic, spitting up, and after feeding distress.*



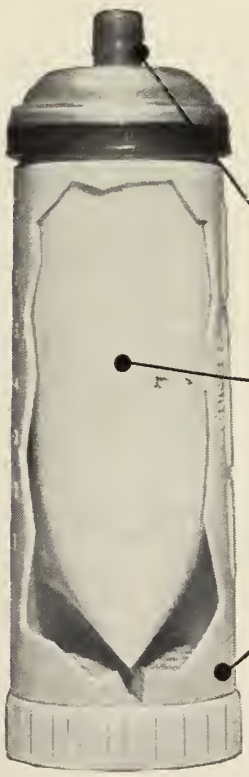
*Natural design nipple of Playtex Nurser assures even flow. Its pliable inner bottle contracts with atmospheric pressure as formula is consumed. Baby takes more nourishing formula, less swallowed air to cause discomforting spitting up and colic.*

# dramatically reduces spitting up and colic

To the members of the medical profession who recognize the advantages of breast feeding—here's a completely new concept in baby feeding that all doctors will welcome. The new Playtex Nurser. It features a soft, pre-sterilized inner bottle which is disposable, and a broad, non-collapsing nipple which produces a sucking action similar to that in breast feeding.

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Colicky infants, problem feeders and premature babies especially will benefit from the breast-like action of the new Playtex Nurser. The fact that the bottle is pre-sterilized and disposable will appeal to mothers who do not breast feed their babies. The fact that the Nurser does so closely simulate breast feeding will be similarly important to the health of any baby fed with it.




(Cut-out View)

*"Nature's Way"*

# PLAYTEX NURSER

*"The nearest approach to breast feeding"*

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*Dosage:* Adults, 1 Caplet (200 mg.) three or four times daily;
children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

*References:* 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

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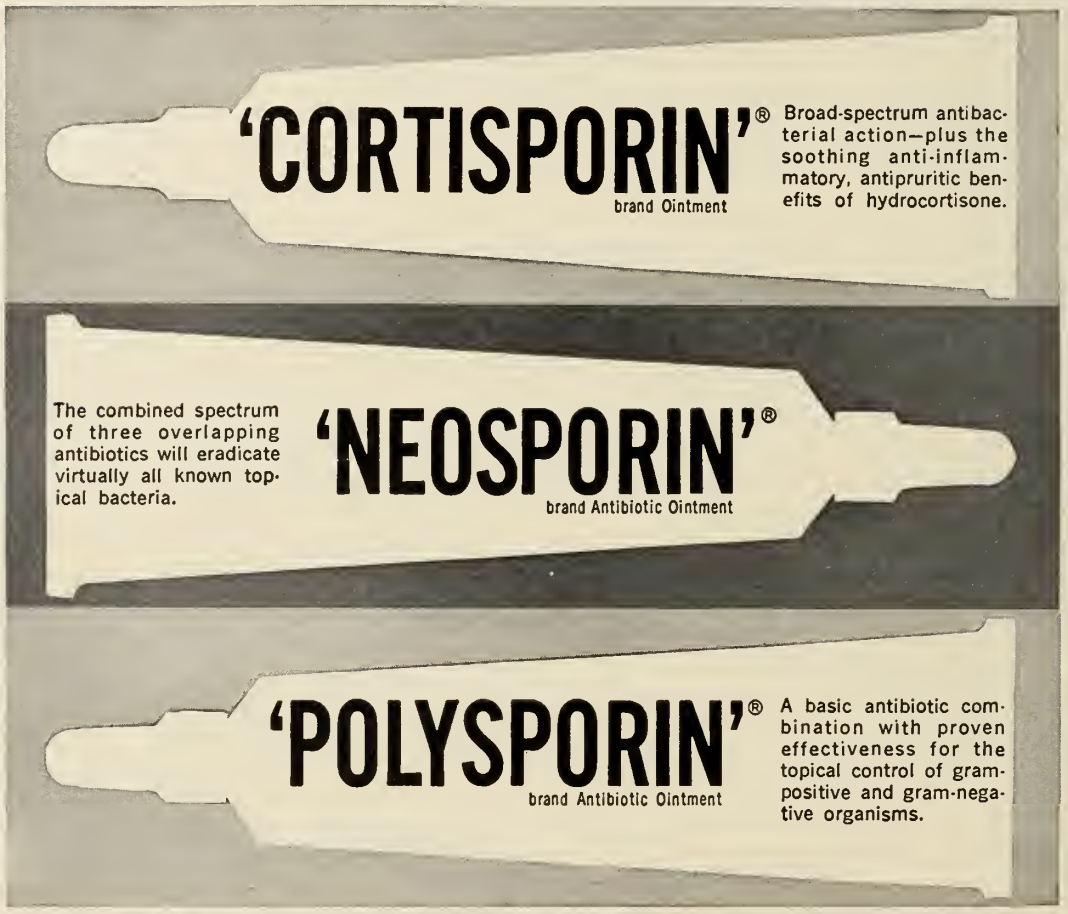
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provides the benefits of Terramycin Intramuscular Solution: rapid effectiveness against a broad range of pathogens; rapid, wide distribution in body tissues and fluids; excellent toleration

### plus . . . all the advantages of the ISOJECT unit:

**convenient** completely self-contained/no intricate assembly/no chance of lost parts

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The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. As with all I.M. preparations, injection should be made within the body of a relatively large muscle. Care should always be taken to avoid injection into a major nerve or its surrounding sheath. For complete dosage, administration, and precaution information, read package insert before using. Terramycin Intramuscular Solution contains 2% (W/V) Xylocaine.*

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# Medical Pioneers in Contraception

## II — Robert Latou Dickinson, M. D., 1861-1950

BRUNO GEBHARD, M.D.*

*(Continued from March 1962 Issue)*

ROBERT LATOU DICKINSON[1] was the first physician of prominence to advocate voluntary birth control, urging its scientific practice by the profession, and was active in the development of the Planned Parenthood Association of America. Robert L. Dickinson published his standard work, "Control of Conception" in 1931. He dedicated it "To the memory of Dr. Charles Knowlton (1800-1850) Fellow of the Massachusetts Medical Society on the hundredth anniversary of the writing of the first medical work on control of conception 'Fruits of Philosophy.' "

A second and enlarged edition of the "Control of Conception" appeared in 1938. The book has 128 original illustrations, all by Dickinson's hand.[2] In the copy I own, an unknown reviewer penciled on the inner leaf these remarks:

> "For sheer artistry both text and illustrations, by R.L.D. are a delight. The second edition of this important contribution to preventive medicine is brought fully up to date. Search for security and simplicity continues; effectiveness — variations necessary to meet different conditions. . . . A source book — anatomy, methods of contraception — abortion when peril to life or health."

Charles Knowlton wrote for the laity. Dickinson wrote for the profession, giving his book the subtitle "A Clinical Medical Manual." The book is part of a series on "Medical Aspects of Human Fertility," issued by the National Committee on Maternal Health, of which Dickinson was the Director since 1923. Dickinson's topographical hand atlas "Human Sex Anatomy" (1932) is one of the best known publications in that series.

Dickinson was 70 years old when he published "Control of Conception" and had still nearly 20 active years ahead of him.

Knowlton was a country practitioner. Besides some occasional trips to New York and Boston, he lived and worked in the northwestern part of Massachusetts. Dickinson was a man of the world. Already as a teenager — he was born on February 21, 1861 — he spent some time in the French-speaking part of Switzerland and the Black Forest of Germany, and became so very fluent in both languages. He was 5 feet 10 inches tall, wiry, a ladies' man, a great accoucheur of the outgoing Victorian era and an enthusiastic teacher.

### Excelled as Artist and Physician

He excelled both with the pen and with the pencil; he was just as much an artist as he was a physician. In a tape-recording, which he made for his grandchildren shortly before his death, he related, "At 17 the best lithographic house in the city (New York) offered me a very good position at a salary that was tremendously tempting for a boy." The artistic temperament he had inherited from his father who was a successful business man.

Dickinson had no formal artistic training, but his medical drawings compare well with those of Max Broedel. His nature studies and his sketches of his walking tours have the marks of great quality. At the age of 72, guided by Malvina Hoffman, he took up sculpturing with the help of Abram Belskie and finished nearly 100 anatomical models on human reproduction, which are now the proud possession of the Cleveland Health Museum.

Dickinson was a deeply religious man, an Episcopalian, and was for many years a vestryman at the Trinity Church in Brooklyn, New York. Politically he was a Democrat. Dickinson, like Knowlton, was of English descent. One of his forefathers in 1799 started the Dickinson Academy, now known as Deerfield Academy, in Massachusetts. There was no medical ancestry either in Knowlton's or in Dickinson's family.

### Childhood Accident Motivates Medical Study

In the previously mentioned Fireside Chat,[3] Dickinson relates about what made him become a physician as follows:

> "About my start in surgery — my father (Horace Dickinson II) and I had built a canoe. According to Baden-Powell, the Boy Scout man, it would be cheap to make it, and father decided we would do it. So we built it, but it was high-sided and cranky. We went up the river (in the Adirondacks) to try it out. Father was to paddle it up

*Dr. Gebhard, Cleveland, is Director of the Cleveland Health Museum.

Presented at the Annual Meeting of The Ohio Academy of the History of Medicine, Granville, Ohio, April 22, 1961.



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and then I was to get in naked and see how much it took to capsize it.

"Father paddled towards the bank — it was about as high as that sofa. I had stripped, and jumped into the water as he came head-on towards me. Just then a little eddy swung the canoe right under me. The stem was of galvanized iron, with the top bent over sharply so that the point was as sharp as a knife. That's what I hit — I put out my hand and missed. I got an eight-inch tear, but held my bowels in and swam ashore."

"Didn't they take you to hospital?" "No, took me to a house, and carried me up indoors. The doctor was so crippled with arthritis he couldn't do anything. So the carpenter had to do it and put in the stitches but missed some things, so I am a little lopsided. He was not very skilled, and when the stitches had to come out, he just cut and pulled them, and they dragged at every cut. My mother leaning over, held my head behind her arm. She wore those long complicated earrings, and when I gasped I got a whole mouthful of earrings. So for the rest of the time I was too busy spitting out earrings to pay attention to the stitches being pulled out.

"I was eight weeks in bed — the wound suppurated — and when I got up I collapsed on the floor. But that man I adored so, that doctor — that's what I wanted to be, a doctor."

### Graduated Before the Age of 21

Dickinson had an early start in his medical career. He finished his final examination at the Long Island College Hospital in 1881, top of his class, but had to wait until he was of the legal age of 21, so that he officially graduated in 1882. He began practicing as a surgeon, specializing soon in obstetrics and gynecology. He married at the age of 29; two of his daughters are still living, and he had a very closely-knit family life. He practiced for many years, first in Brooklyn and later had offices in Manhattan. Around 1900, his professional card states that his office hours were at 8:30 a. m. and from 2 to 5 p. m., except Sundays and Thursdays. His card lists two different telephone numbers.

After World War I, Dickinson turned from the clinical aspects of gynecology and obstetrics more to the physiological side of marital relations and to the social and economical aspects of maternal health. He retired from practice in 1924. Already in 1920, as President of the American Gynecological Society, he delivered a statesmanlike address under the title "A Program for American Gynecology[4] chiding his colleagues of being too often and too quick with the knife, calling for the sterilization in women who are idiots, epileptic, hopelessly insane or incurably criminal, endorsing artificial impregnancy, "another of this distasteful subject we naturally shrink from," and made an urgent plea for more research and scientific practice of contraception.

Dickinson was not an alarmist. He enjoyed life enormously, was a long-range optimist. Said he in 1935, "As a student of marriage of some 50 years standing, I find that marriage is not what it was; it is better, not worse." At the occasion of his presidential address, he stated, "As marriage is an experience in procreation, without preliminary tests for fitness or institution in method . . . it should be considered satisfactory that there occurs something like 90 per cent success." Some of his colleagues who didn't concur in his opinions and thought him a radical, called him "Sentimental Tommy."[5]

### Collects Sex Histories Before Kinsey

Dickinson was a very systematic man. By 1930, shortly before he published his book, "One Thousand Marriages"[6] he had accumulated over 5,200 of his own clinical case histories. Separate sheets for sex histories, in his own personal code, were made of 1,200 cases, the first one dated 1890. Many of these case histories cover the entire reproductive period of his patients. They all carry clinical illustrations, five as an average, but the number might go on as high as 30 as in the case of a woman he took care of for 29 years.[6] Most of his patients came from middle-class and upper-level homes. Regarding the truthfulness of the sex histories, Dickinson was fully aware that they were not 100 per cent reliable ones. Said he, "The reader has but to remember that about sex, he himself has never told all . . . Sex is so important that we color it a little to enlarge ourselves, the woman wishing the reputation for purity or passion."

For Dickinson the central issue of marriage was fertility, but, nevertheless, he became the most ardent fighter of our days for control of conception. He saw too much of what he called "sexual unhappiness" and said once, "Fear is the second word in the vocabulary of sex."

### "The Decision Is Not the Doctor's"

The opening chapter, called "Forethought," states Dickinson's basic approach toward safeguarding the health of mothers. He says, "Protection, — beyond peradventure, for nearly four million occasions each night for this country alone — this is our urgent medical marriage problem. Between pregnancy and prevention the decision is not the doctor's, save for disease and disorder."

Dickinson was no advocate for a single method as the best and only one, but he preferred those "which could be used by the hands of the partner most concerned — the wife."

Dickinson liked to quote himself that in this field "facts must be sought that facts may be taught." Alfred C. Kinsey, who looked for facts on a broad statistical basis has acknowledged his indebtedness to Dickinson. Dickinson's uniqueness was a fearless inquiry in the daily practice of contraception, a critical analysis of the pros and cons of the different methods and techniques continuously coming up. Through all this he immersed his own philosophy as "All search for the good life is tied to the search for the good in sex life. Birth control widens this field of search immeasurably." (page 87). His book is not without humor and sometimes of the sarcastic kind, as in his "Prescription of Total Abstinence" he says, "Beware of anything and everything that might start to rouse sexual desire . . . if only one bed . . . then to bed and out again at different times . . . beware

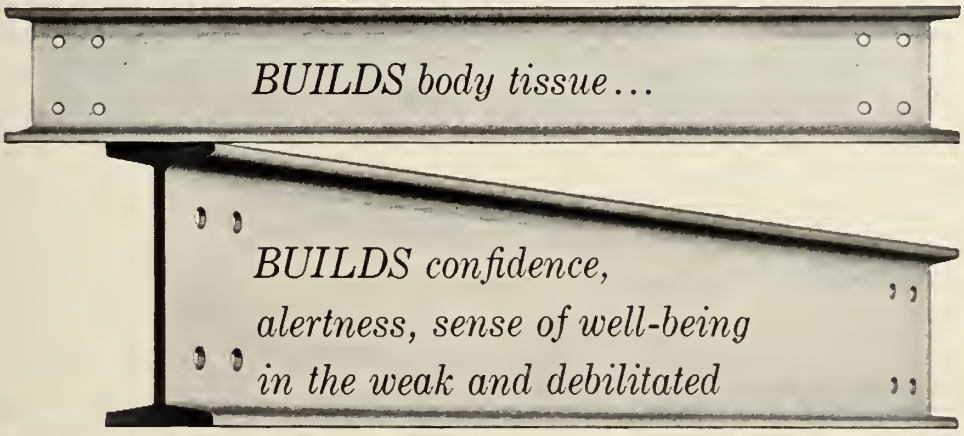
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of quarrels — they end in reconciliation and affection." (page 90)

### Against the Tabu of Self-Examination

Dickinson was anxious to achieve two purposes with this book, "the submission of contraception methods to obstetricians, gynecologists *and* the practitioners," and secondly, the stimulation of research. He was known to his contemporaries for the minuteness of his own studies, the restless search in the world literature and in his obstinancy in what he thought was right or wrong.

Dickinson did not take anything for granted whether it was in the domain of the physician or the patient. As an example, Knowlton wrote only a couple of sentences about the douche; Dickinson devoted a whole chapter to it with two dozen illustrations. He expanded this section for the second edition in word and diagram, as in his opinion "there are few parts of the body more difficult for the lay mind to understand than the vagina — whether this has to do with depth, or shape, or direction. Yet this haziness will disappear with removal of the tabu on self-examination." Such a tabu exists with many members of our present generation and has not yet been overcome regarding self-testing of women for cancer clues via the Papanicolaou method.

Fighting tabus, in order to facilitate wider use of contraceptive methods, got Dickinson interested in advocating the use of tampons as menstrual guards. Here, again, he had to fight his medical colleagues. Replies to questionnaires mailed out to 3,400 doctors by one of Dickinson's adversaries indicated that 80 per cent of them were opposed to the use of menstrual tampons.[7] Some physicians objected out of clinical reasons but mostly on the assumption that the use of tampons might destroy the evidence of virginity, but Dickinson proved that this was not the case.[8]

### Lasker Award Winner

As Dickinson was well-known and respected in the more accepted and more respectable fields of obstetrics and gynecology, he succeeded in instructing the coming-up generation of specialists in the field of birth control. In 1946, he won the Lasker Award jointly with the Planned Parenthood Federation of America.

In one of the closing chapters of the book, which might be called a "Confession of Faith," Dickinson gives his indications for a justified control of conception:

> "Contraception is in order wherever childbearing means unwarranted risk for mother or child, for family or community. Every person has a right to know that control of conception and spacing of children is feasible. Without it, life as a whole cannot be planned. Postponement of pregnancy and protection for affection — whenever requisite or desirable — is mere sense. It is not just theory, philosophy or high wisdom, worldly or spiritual. Therefore, it is not thinkable that any profession that possesses or develops it can withhold the information, nor can any church suppress what belongs to sane living and success in home making."

Dickinson looked at control of conception as an important part of the broad field of sex education and conjugal hygiene. He scolded his medical colleagues for "our past and present silences in medical textbooks and medical colleges — a timidity or cowardice inexcusable in a matter of their professional duty." (page 339)

The closing chapter, entitled "The Gist of Birth Control in Diagram" has become the bane of librarians as these pages are often missing from the book. Dickinson found these illustrations necessary "on account of the haziness of the interior regional anatomy and action, the crude or misleading attempts in lay writing and the striking avoidance in medical and scientific publications." (page 341)

For Dickinson, control of conception was in the same line as the great strides made in the control of pain in labor and operation, the control of infection and of communicable diseases. Following are the concluding sentences of his pioneer book: (page 352)

> "These three advances made in the face of opposition and indifference on the part of the organized profession, are now its common pride and glory.
>
> "A Fourth control, control of conception, needed to safeguard life and health and happiness, though still suspect and maligned, will take its place of honor with these others. Courage and wisdom were required to restrain the forces of disease and death. A greater courage and a higher wisdom are called for within our profession to undertake a guiding part in the control of life."

### Lives to Age of 89

Dickinson died on November 29, 1950, at the age of 89. His ashes were taken to the high crest of the Palisades on the Hudson River and cast to the winds from the basalt pinnacles, named by the Indians "The Gateway of the Great Spirit."[9]

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*Schaefer, L. E.: Clin. Med. 8:1343, 1961.

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# Histoplasmosis in Children

THOMAS S. MORSE, M.D., and LOYD SCHULTZ, M.D.

PRIOR to 1934 histoplasmosis in children was unknown. Today it is encountered with some frequency. In the past 12 years a diagnosis of histoplasmosis has been made in 30 children admitted to the Columbus Children's Hospital. While most of the children were medical patients, others were admitted directly to the general surgical, neurosurgical thoracic surgical, and orthopedic services. The wide range of disorders mimicked by histoplasmosis in children emphasizes the need not only for pediatricians but for surgeons to have a working knowledge of the disease.

## History

The steps by which this knowledge has been amassed are reviewed by Schwartz and Baum.[1] The organism was first recognized by Darling[2] in 1906 in the organs of a man dying of the disease. The first diagnosis in a living child was made nearly 30 years later by Dodd.[3] This child died, and from the blood and organs, DeMonbreum[4] cultured the organisms for the first time. He described the saprophytic mycelial form which can be grown at room temperature, and the parasitic yeast form which grows under conditions of high humidity and at body temperature. There follow several reports[5,6] outlining the characteristic clinical course and autopsy findings of fatal cases in children. The similarity of many of these to tuberculosis was emphasized with the important exception that histoplasmosis was felt to be universally fatal.

From the Department of Surgery, The Ohio State University College of Medicine, and Department of Pediatric Surgery, The Children's Hospital, Columbus, Ohio.

Submitted July 10, 1961.

*The Authors*

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● **Dr. Schultz, Columbus, is chief resident in pediatric surgery, Columbus Children's Hospital; instructor in surgery, The Ohio State University College of Medicine.**

In 1944 Christie[7] noted that many people with calcific lesions in their chests reacted positively to the histoplasmin skin test and negatively to tuberculin. These completely asymptomatic individuals were shown by Palmer[8] to be much more numerous in certain states than in the nation at large. Hence, while the disease is worldwide, most of the cases arise in a limited endemic area consisting of Illinois, Ohio, Iowa, Kansas, Tennessee, and Missouri.

There was for a time a gap between the many asymptomatic cases and the few fatal ones. Finally, Blumberg et al.[9] in 1949 and Wheeler et al.[10] in 1950 reported histoplasmosis in patients with a wide range of symptoms who eventually recovered.

## Clinical Material

The present series extends from the beginning of 1948 through the end of 1960. There were 22 pa-

tients in whom a diagnosis of histoplasmosis was established by serologic studies, cultures, biopsy or autopsy. We have included in a separate category eight patients with positive skin tests and roentgenographic findings compatible with a diagnosis of histoplasmosis.

Of the 30 patients, 19 were boys; 11 were girls. Three were under a year of age. Ten were under the age of 4 years. The oldest was 14 years. The greatest number of admissions in a single year was six.

### Influence of Age

Two general patterns of illness were seen. The younger patients tended to be more acutely ill than the older ones. They were apt to show lethargy, fever, splenomegaly, hepatomegaly, anemia, leukopenia and failure to gain weight. They might or might not have coryza and cough, but in general, respiratory symptoms were less prominent than in older children. All but one of the deaths occurred in children less than 4 years old, a mortality of 40 per cent in this age group.

The older children were less acutely ill, seldom had splenomegaly or hepatomegaly, and almost never showed anemia or leukopenia. They tended to have mild respiratory symptoms as their major complaint. Discretely enlarged non-tender lymph nodes were frequently the only abnormal physical finding (Fig. 1).

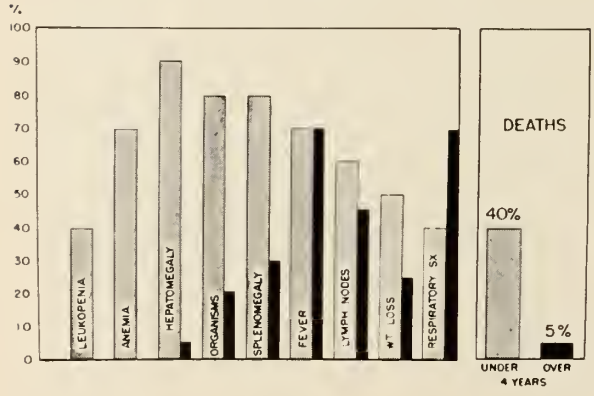



FIG. 1. *Dissemination with multi-system involvement is the rule in infants and young children, (grey bars), while older children, (black bars), are better able to localize the disease. Mortality in infants is far higher than in older children.*

### Complaints and Findings

The wide range of presenting complaints is tabulated in Table 1.

TABLE 1. *Presenting Complaints*

| | | | |
|---|---|---|---|
| Fever | 13 | Coma | 1 |
| Anorexia | 5 | Headache | 1 |
| Cough | 3 | Back Pain | 1 |
| Abdominal Pain | 2 | Asthma | 1 |
| Pleural Effusion | 1 | | |

Nineteen patients gave a history of a relatively acute and two of an insidious onset of respiratory symptoms which failed to clear on antibacterial therapy. In the remaining nine patients a variety of non-respiratory complaints were the first symptoms.

The family history was positive for histoplasmosis in four instances, and for tuberculosis in six.

Physical examination of the chest revealed very little, except for a few patients who showed localized decrease in breath sounds. Other abnormal physical findings are tabulated in Table 2.

### X-Ray Frequently Provides Tip-off

The admitting diagnosis was correct in only one case, although histoplasmosis was included in the differential diagnosis nine times. We estimate that in at least 11 instances the chest roentgenogram provided the first suggestion of the correct diagnosis. These findings, tabulated in Table 3, resemble in every detail those found in childhood tuberculosis. While patients with simultaneous histoplasmosis and tuberculosis have been reported, none has been encountered in this hospital.

TABLE 2. *Physical Findings*

| | |
|---|---|
| Enlarged Non-Tender Nodes | 16 |
| Splenomegaly | 13 |
| Hepatomegaly | 9 |
| Jaundice | 2 |
| Central Nervous System Irritation | 2 |
| Otitis Media | 1 |

TABLE 3. *Chest Roentgenographic Findings*

| | |
|---|---|
| 1. No Abnormality | 4 |
| 2. Hilar Adenopathy and/or Infiltration *without* Calcification | 18 |
| 3. Infiltration *with* Calcification | 3 |
| 4. Infiltration and Pleural Effusion | 1 |
| 5. Calcification Only | 2 |

The diagnosis was established by skin test, complement fixation, agglutination test, culture, biopsy or autopsy. The most conclusive evidence for the diagnosis of histoplasmosis in each of the cases is tabulated in Table 4.

TABLE 4. *Single Most Conclusive Diagnostic Test In Each Case*

| | |
|---|---|
| Chest X-Ray and Skin Test | 8 |
| Serologic Test | 10 |
| Culture | 4 |
| Biopsy | 3 |
| Autopsy | 3 |

TABLE 5. *Sedimentation Rate in Clinically Active Cases*

| | | |
|---|---|---|
| Under 20 mm./hr. | 1 | (Age 2 years) |
| 20 to 40 mm./hr. | 5 | ( |
| | | (All 3 years old or older) |
| | | ( |
| | | ( |
| 40 to 60 mm./hr. | 7 | ( |

The sedimentation rate (Table 5) was elevated in 13 of 14 clinically active cases. In seven cases it was over 40 mm./hr. The one active case (proven by splenectomy) with a normal sedimentation rate of 6 mm./hr. was a child 2 years old. One child whose

chest roentgenogram showed pulmonary infiltration and hilar adenopathy with minimal calcification had a sedimentation rate of 56 mm./hr. Two months later there was regression and her sedimentation rate had fallen to 8 mm./hr.

### Surgical Procedures

Six children underwent surgical procedures. These are tabulated in Table 6.

TABLE 6. *Surgical Procedures*

| | |
|---|---|
| Splenectomy, Liver and Node Biopsy | 1 |
| Splenectomy and Node Biopsy | 2 |
| Cervical Node Biopsy | 1 |
| Mediastinal Node Biopsy | 1 |
| Pericardiectomy | 1 |

In none of the patients was bleeding excessive, although hemorrhagic tendencies associated with thrombocytopenia have been reported.[11] Operation was diagnostic but not therapeutic in five patients. One of these died 12 hours after being started on amphotericin B. The others survived. The sixth patient benefited directly from excision of the thickened constricting pericardium in which organisms could be seen under the microscope.

### Specific Medical Therapy

Antifungal therapy was given to four patients. One received Atabrine® and died, another received quinine with rapid resolution of fever and complete recovery. One whose diagnosis was made by splenectomy lived only 12 hours after starting amphotericin B therapy. The fourth, also diagnosed by splenectomy, was extremely ill but made a gradual recovery after a course of amphotericin B.

### Deaths

Five patients died. All but one were less than 4 years old. Two showed evidence of severe central nervous system irritation prior to death. At autopsy three showed widespread distribution of the organism in the brain, meninges, lungs, liver, spleen, lymph nodes, and bone marrow. Two were correctly diagnosed prior to death. One was suspected, but confirmation by culture was obtained only after the child died.

### Discussion

In dealing with these 30 children with histoplasmosis, difficulty has been encountered in three areas. The first is that of recognizing the child who might have the disease. This is reflected in the fact that in only one third of the cases was histoplasmosis listed in the admitting differential diagnosis. The second difficulty is that of establishing the diagnosis. The third involves the selection of patients for specific medical therapy.

### Whom To Suspect

Especially in endemic areas, the diagnosis of histoplasmosis should be considered in two groups of children. The larger group includes children over the age of 4 years. They manifest mild but lingering respiratory symptoms. Most of these will have chest x-ray findings virtually indistinguishable from those of childhood tuberculosis, and will have a negative tuberculin skin test.

The second group, about half as numerous as the first, is made up of infants and children under the age of 4 years. These are children manifesting some or all of the following unexplained findings: fever, anemia, leukopenia, hepatosplenomegaly, central nervous system irritability, and failure to thrive. Diag-



FIG. 2. *Chest roentgenogram of an 8 year old boy with fever, anorexia and cough. The resemblance to childhood tuberculosis is striking. Hilar adenopathy is seen during the active phase of the disease.*



FIG. 3. *Chest roentgenogram of the same child two years later. As in tuberculosis, the hilar swelling recedes and calcifications appear. Clinical illness at this stage is usually due to some disease other than histoplasmosis, though skin and serologic tests may be strongly positive.*

nosis is especially important in this latter group because the mortality is high, in our cases 40 per cent.

## Establishing the Diagnosis

As in childhood tuberculosis, the diagnosis of histoplasmosis by culture is often extremely difficult. In general, the more minimal the symptoms the more difficult it is to culture the organism. In this series, repeated cultures of blood, bone marrow, cerebrospinal fluid and biopsy specimen gave a positive culture prior to death in only five instances. In one of our cases, the organism could not be cultured from autopsy specimens even though many organisms were seen microscopically. In all, the organism was either seen or cultured in only about a third of these hospitalized cases.

Since patients with histoplasmosis develop antibodies, complement fixation tests and colloid agglutination tests on serum have been developed. Serologic tests showing a rising titer or very high initial titer are very helpful, and may be the most conclusive evidence of infection available. The levels of antibody do not remain very high for more than a few weeks before they fall to low, but still abnormal levels.[12] To be of value, skin tests and serologic tests showing low abnormal titers must be interpreted in the light of other findings. If these include a history of a long illness, a normal sedimentation rate, and a chest roentgenogram with dense calcifications, the disease is probably inactive. A different explanation for current symptoms should be pursued. On the other hand, any evidence of antibody formation associated with a fairly brief history, a high sedimentation rate, and a chest roentgenogram showing infiltration rather than calcification suggests a diagnosis of active histoplasmosis.

Biopsy provided the diagnosis in about a fifth of our cases. We have had cause to regret delaying too long in deciding to operate on a very sick baby. It is well to remember that the patient who appears least likely to tolerate surgery is the one who most desperately needs a correct diagnosis.

Some of these patients will not require antifungal therapy. The diagnosis is important, however, because during a period of watchful waiting, therapy aimed at other suspected diseases such as tuberculosis can be deferred. In five of our cases the positive diagnosis of histoplasmosis removed a heavy suspicion of malignant tumor.

## Medical Therapy

The evaluation of specific antifungal therapy is very difficult. Our untreated patients demonstrated all patterns of recovery from very rapid lysis of symptoms to improvement at an almost imperceptible pace.

Two forms of medical therapy appear at present to be of value. The first is amphotericin B. This was not available to most of the patients in this series, but we believe that it saved the life of one of them. The second is the sulfonamides which have recently been shown[15] to be effective in inhibiting the growth of organisms. To be effective, serum sulfonamide levels similar to those used in treating bacterial meningitis are necessary, and low levels not only permit but may actually enhance growth of the organism. We have had no experience with the use of the sulfonamides, but their relative safety makes them appealing. Pending further study we believe either amphotericin B or a sulfonamide should be used in children under the age of 4, and in older patients who have disseminated disease as suggested by hepatosplenomegaly, positive blood or marrow cultures, leukopenia or evidence of central nervous system involvement. They should not be used in older children with pulmonary calcification and normal sedimentation rates, for in all probability their disease is inactive and is not responsible for current complaints.

## Summary

Histoplasmosis in children is not rare. Thirty such cases have been studied on the wards of the Columbus Children's Hospital during the past 12 years.

The disease tends to be severe in children under the age of 4 years. Disseminated disease is the rule in this group, and is manifested by fever, anemia, leukopenia, hepatosplenomegaly, central nervous system irritability and failure to thrive. The mortality in our series of 10 children under 4 years of age was 40 per cent. The older children tend to be less ill, and are more able to confine the disease to the chest. The mortality for 20 children 4 to 14 years old was 5 per cent.

The correct diagnosis is often first suggested by the roentgenogram. The findings are almost identical with those of childhood tuberculosis. Co-existence of tuberculosis and histoplasmosis was not encountered during this 12-year period. The diagnosis was made during life by culture in only five instances. Including autopsy material the organism was either seen or cultured in only about a third of the cases.

The skin test and serologic tests are reliable if interpreted in the light of other information bearing on the duration of illness. Those factors favoring the existence of active histoplasmosis are: (1) a fairly short history, (2) an elevated sedimentation rate, and (3) a chest roentgenogram showing predominately pulmonary infiltration and hilar adenopathy. Those factors favoring remote or inactive disease are: (1) a long history of illness, (2) a normal sedimentation rate, and (3) roentgenograms showing predominately calcification in the chest. Symptoms concurrent with these findings are usually not due to histoplasmosis.

Biopsy was required for diagnosis in a fifth of our patients. Biopsy without undue delay should be performed in difficult cases.

The evaluation of specific antifungal therapy is difficult because many children recover without it. How-

ever, we believe it should be employed in all cases diagnosed under the age of 4 years, and in older children with evidence of disseminated disease. At present the drug of choice appears to be amphotericin B or one of the sulfonamides.

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STEROIDS IN INSULIN-RESISTANT DIABETIC ACIDOSIS. — The clinical features in the case of a 25 year old Negro woman included (1) a history of the requirement of intermittent insulin therapy, (2) an insulin resistance that was related to allergy, (3) episodes of insulin resistance that were followed by long periods during which insulin was not required or during which hypoglycemic reactions took place, and (4) an acute episode of hypotension and apnea (following large doses of insulin) which probably represented anaphylactic shock.

Although this woman had had an abscess on her thigh previous to the development of resistance and although she had profound acidosis, it is most probable that the development of insulin resistance was associated with the appearance of an "insulin-neutralizing substance." Another factor which was considered in this patient's case was that when angioneurotic edema had appeared five days before hospitalization, she had been given 10 mg. daily of prednisone for the four days thereafter and insulin had been discontinued. It is probable that the prednisone caused some increment in gluconeogenesis which, in combination with the withdrawal of insulin, was deleterious. Because of the small steroid dosage used, it appears unlikely that this would implicate prednisone in the development of insulin resistance.

At a time when the patient's serum acetone was positive in a 1:8 dilution, respiration was Kussmaul in nature at 24 per minute, vasopressors were necessary the patient was stuporous, and her blood sugar showed no response to the intravenous administration of 500 units of crystalline insulin, it was decided to use steroid therapy to overcome insulin resistance. She was given an infusion of 100 mg. of hydrocortisone, an intravenous injection of 100 mg. of hydrocortisone-hemisuccinate, and an intramuscular injection of 200 mg. of cortisone acetate. Four hours later, she showed marked improvement, was responsive and oriented, and serum acetone was present only in undiluted serum. Hydrocortisone (100 mg.) was given again the following day and cortisone was gradually discontinued over the next four days. At the time of writing, the woman was being maintained successfully on 10 units of NPH insulin daily. — ABSTRACT: James R. Brayshaw, M. D., and Robert G. Petersdorf, M. D., New Haven, Conn.: *Bulletin of the Johns Hopkins Hospital,* 106:143-153 (March) 1960.

# Relief of Pain in Infant Teething

## Double-Blind Study of a New Choline Salicylate Agent

L. E. PALMER, M. D.

THE period of primary dentition in infants is nearly always a difficult one for both the child and its parents. That the process is painful to the infant is manifest to parents and the medical attendant through its crying, fussing, refusal to eat, and other signs of discomfort. The gums are red and inflamed. Fever sometimes accompanies teething in the infant, and, less often, there are associated upper respiratory infections and gastrointestinal disturbances, probably due to disturbance in the infant's rest and eating patterns.[1]

For the parent it is a time of anxiety, the intensity of which is related to his or her previous experience. Although some can and do regard the process and its associated distress with comparative equanimity as "a natural thing," there is no reason for the physician to neglect either the infant's pain or possible systemic effects, if analgesic relief can be offered.

While acetylsalicylic acid has well-known analgesic and antipyretic properties, it also has drawbacks which militate against its local or systemic use for relief of pain in primary dentition. These are: (a) occasional gastrointestinal disturbances[2]; (b) an acid pH which may irritate local tissue and damage the enamel of the emergent tooth[3]; (c) insolubility, which makes difficult the efficient application of a minimal effective quantity.

Availability of a teething gel, reported to be simple, safe, and effective, with an approximately neutral pH, provided opportunity to test the efficacy of a new agent in this field. The teething gel contains, besides flavoring ingredients and vehicles, choline salicylate as an anti-inflammatory and analgesic agent,[4] and cetyldimethyl benzylammonium chloride as an effective surfactant germicide[5] to reduce the threat of infection in the areas of dental eruption.

### Methods and Materials

The gel was evaluated by a double-blind study in which neither physician nor parent was informed whether active or placebo gel was used. One group of 46 teething infants, from 4 to 15 months of age, was treated with the active teething gel, and a control group of 40 infants of similar age distribution was treated with a placebo gel. All the infants showed objective signs of distress, such as fussiness, drooling, and crying. About one-third refused food. Two-thirds had gingival hyperemia, and two-thirds gingival edema. Of these, one-third of the total number showed both.

A small portion of either preparation was carefully massaged on the infants' gums. After initial application in the office to familiarize the mothers with the method, they were instructed to apply the gel four times daily, after feeding and at bedtime, as long as there were recurrent signs of distress. The mothers were instructed to time the latent period between application and apparent relief.

Complaints from the mothers of teething infants can be expressed in three broad classifications: restlessness, anorexia, and fever. The first two are common, but fever is a nebulous quantity when determined (on the mother's part) by the feel or appearance of the child, as it frequently is in these situations. Consequently, fever was omitted as a criterion of success or failure of the teething gel medication, and restlessness and anorexia were used as indices. The criteria established for the investigation were as follows: if both restlessness and anorexia were much improved, the result was considered excellent; if one was much improved or both moderately improved the result was considered fair. Anything less than this was considered a poor response.

### Results

Using these criteria, the results of the active gel were 35 (76 per cent) excellent; 9 (20 per cent) good; and 2 (4 per cent) poor. For the placebo, the results were 9 (22.5 per cent) excellent; 15 (37.5 per cent) good; and 16 (40 per cent) poor. No side effects of any kind were noted. These results,

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*The Author*

● **Dr. Palmer, Dayton, is a member of the attending staffs of Good Samaritan Hospital, Miami Valley Hospital, and Barney Hospital; Medical Director, St. Joseph's Orphange.**

summarized in Table 1, were subjected to statistical analysis* and were found to be highly significant.

The latent period between application of the active gel and apparent effect was from 5 to 30 minutes, with an average of 16 minutes, in the entire teething gel series. In 14 cases the latent period was from 15 to 30 minutes, in 25 it was 10, and in seven cases 5 to 8 minutes. In the control group the latent period for the nine cases with excellent results was approximately the same as for the entire series with the active gel. The 15 good results followed a somewhat longer latent period, ranging between 45 minutes and

TABLE 1. *Comparison of Effects of Active Gel With Those of Placebo Gel*

| | Excellent | Good | Poor | Total |
|---|---|---|---|---|
| Active | 35 (76%) | 9 (20%) | 2 (4%) | 46 (100%) |
| Control | 9 (22.5%) | 15 (37.5%) | 16 (40%) | 40 (100%) |

1 hour. No effect at all was noted in the 16 cases with poor results. No significant relation appeared between condition of the gums or age of the infant on the one hand, and results or length of latency on the other.

## Comment

Of the nine parents in the placebo group who reported excellent results, three had been given the active gel in a previous screening study and were so pleased they asked for more. These mothers were probably influenced in their reports by the enthusiasm they carried over from the previous experience. The other six with excellent and the 15 with good results indicate the usual placebo effect on the emotionally involved observer.

Acceptance of the active gel by parents was good to enthusiastic; in only one instance, in which the infant's gums were exceptionally edematous and hyperemic, could parent acceptance be characterized as only fair, though the results were good.

This study, together with previous clinical observations in a pilot study conducted by the investigator, indicate that choline salicylate teething gel is effective in relieving the pain and distress associated with primary dentition.

## Summary

1. A choline salicylate teething gel** was applied to the gingivae of 46 infants from 4 to 15 months of age, who were evidently suffering from the pain and distress of primary dentition. A control group of 40 infants of parallel ages and condition was treated with a placebo.

2. Excellent results were reported for 35 and good results for nine of the group treated with the active gel. In the control group, excellent results were reported for nine, good results for 15, and poor response for 16. No side effects were observed in either group.

3. The teething gel appears to have definite value in the alleviation of pain and distress associated with the primary dentition of infants.

*To determine the statistical significance of the findings in this study I used the number of cases in which results were obtained (i. e. excellent and good) as against no results (poor). This to some extent rules out subjective errors and certainly penalizes the active group much more than the controls.

To find the standard error of difference between these two, I used the proportion: $\sqrt{\frac{p \times q}{n} + \frac{p' \times q'}{n'}}$ = standard error.

Where p = the percentage of active cases with results, q = the percentage of active cases with poor results and n = the number of active cases. p', q' and n' are similar figures for the control group. The formula then is:

$$\sqrt{\frac{96 \times 4}{46} + \frac{60 \times 40}{40}} = 8.27$$

If the difference between the two proportions is twice the standard error the results are said to be significant. In this case:

$$\frac{96 \times 4}{46} = 8.35; \quad \frac{60 \times 40}{40} = 60; \quad 60 - 8.35 = 51.65$$

$51.65 \div 8.27 = 6.25$ times the standard error. Therefore the probability of error in these results is 1 in 100,000.

**Supplied as Teejel® by the Medical Department of The Purdue Frederick Company, New York, N. Y.

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## Mucoid Impaction of The Bronchi

Mucoid impaction of the bronchi is a complication of chronic bronchial asthma or obstructive bronchitis that occurs as the result of narrowing of the bronchial lumen, secretion of a viscid mucus, and dehydration of the secretions. If the patient is unable to expel this obstruction, the impaction enlarges progressively and causes continued dilatation of the bronchus that encloses it, followed by chronic pneumonitis, bronchiectasis, and formation of abscesses.

The clinical and roentgenographic features of bronchogenic carcinoma and pulmonary tuberculosis may be simulated by mucoid impaction.

Surgery is indicated for irreversible secondary pulmonary suppurative disease, and is frequently necessary as a means of establishing the true diagnosis in instances where bronchogenic carcinoma or pulmonary tuberculosis are diagnostic possibilities. — James B. Hutcheson, M. D., Robert R. Shaw, M. D., et al., Dallas, Texas: *American Journal of Clinical Pathology*. 33:427-432, May 1960.

# Vectorcardiography

## Introduction of a Simple Lead System

M. HALMOS, M.D., ELIAS SAADI, M.D., and L. P. CACCAMO, M.D.

IN 1958 the Cardiovascular Laboratory of Saint Elizabeth Hospital was awarded a grant by the Youngstown Area Heart Association to study the value of vectorcardiography in evaluating clinical exercise tolerance tests. During the period of the next two years the limitations of the various vector lead systems became apparent. This resulted in the development of a method of lead placement which is the subject of this report.

Other methods of vector lead placement have been based upon the assumption that during the cardiac cycle the heart is a fixed dipole of negligible size located in the hypothetical center of an homogenous conducting medium.[1] Surface leads are located in such a manner as to yield transverse, vertical, and sagittal (orthogonal) components of the heart voltages. Through the magic of the cathode ray tube two of the above orthogonal leads, from which ordinary electrocardiograms may be taken, can be combined to yield a vectorcardiogram in the appropriate plane (frontal — horizontal — sagittal).

According to Johnston if three leads can be devised that will yield satisfactory scalar orthogonal electrocardiograms,[2] these leads would be ideal not only for vectorcardiography but would also provide a method by which most of the data now required by 12 leads could be recorded in three. Our early investigations reaffirmed Johnston's[2] statement that if vectorcardiographic excellence and accuracy can be judged on the basis of the nature of the scalar orthogonal leads employed, then it must be conceded that the present cube and related systems are not very satisfactory.


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- **Dr. Caccamo, Youngstown, is co-ordinator of the Department of Internal Medicine, associate director of Medical Education, and director, Department of Cardiology and Electrocardiography, St. Elizabeth Hospital; instructor in Physiology, Youngstown University.**


Disregarding the previous assumption of the heart as a fixed dipole located in the hypothetic center of the torso, we conceived of a different approach which we felt reduced the errors introduced by body contour, variation of the anatomic cardiac position and electrode placement from subject to subject.[3] The apex or point of maximum impulse was chosen as our main reference point. This is easily located and accurately defined in most instances. A positive electrode is placed at this point. The right border of the heart is then located by percussion and a negative electrode is placed here in the same horizontal axis as the previous electrode. This bipolar lead is called X or the horizontal lead. The other two leads (Y, vertical and Z, sagittal) are obtained by placing negative electrodes at the positions noted in figure 1, observing the principle of equidistance and perpendicularity.

In other words, utilizing standard lead I of the usual

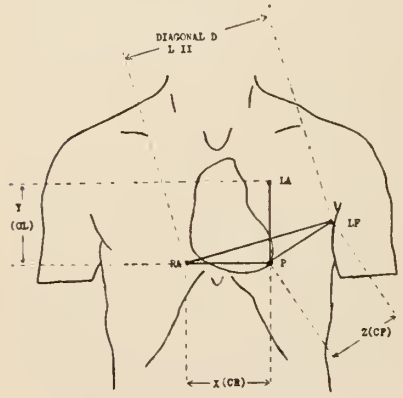
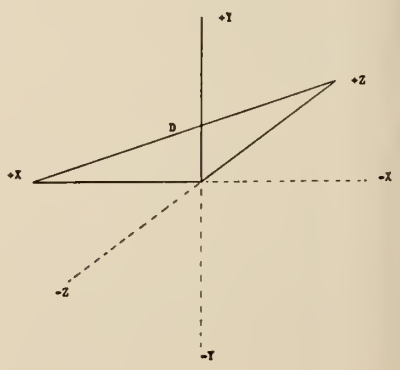



FIG. 1-a. *(Left). Electrode placement of the Apical - orthogonal - equidistant lead system.*

FIG. 1-b *(Right). Illustrates the spatial orthogonal axes of the lead system. The careful observer immediately notices some contradiction between our reference system and conventional methods. Although the flow is directed toward the apex, the positive direction of the coordinates points away from the apex.*



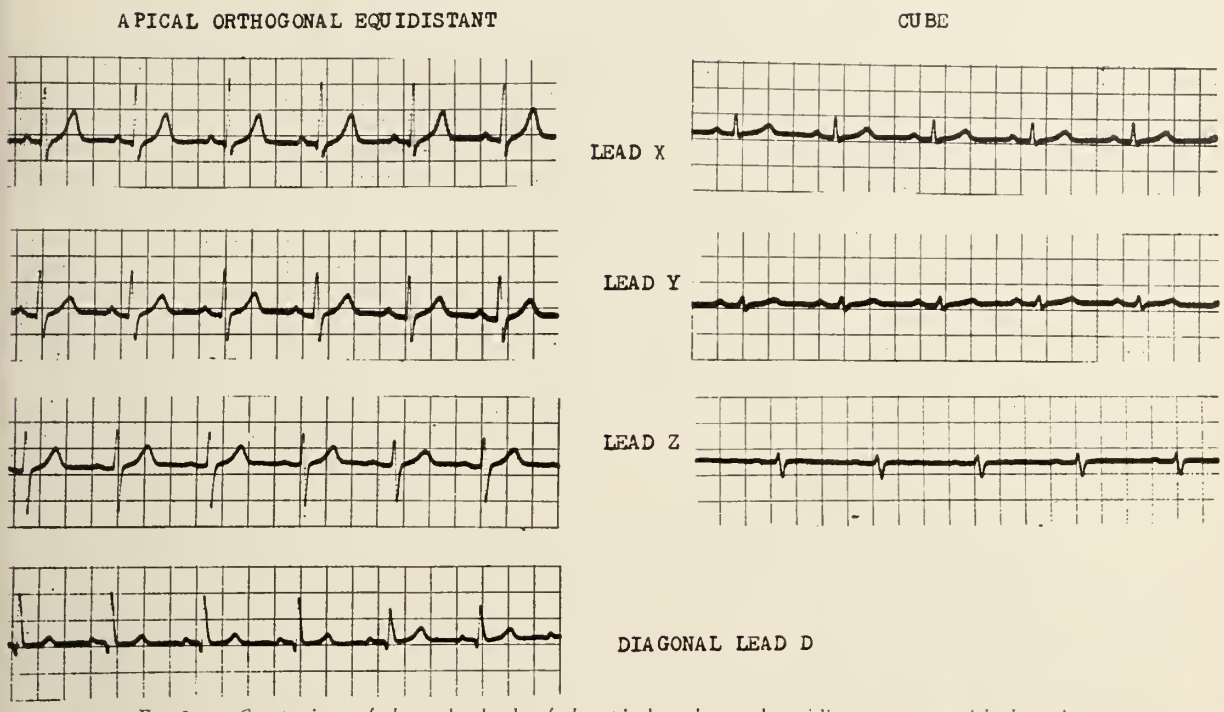



FIG. 2-a. *Comparison of the scalar leads of the apical- orthogonal-equidistant system with the cube.*

electrocardiogram, a bipolar lead where right arm (RA) is negative and left arm (LA) is positive, LA is placed at the apex of the heart and RA at the right border at the level horizontal to LA giving us lead X. Leaving LA at the apex, RA is rotated 90 degrees placing it usually under the left clavicle. This is the vertical lead Y. RA is rotated 90 degrees more and placed on the same plane as lead X usually at the posterior axillary line giving lead Z, the sagittal lead.

A simple technique of placement requiring only one application of the appropriate electrodes can be carried out by placing the unipolar electrode P at the apex and the right arm, left arm and left foot electrodes of the conventional electrocardiogram at the points so labeled in figure 1. The X, Y, and Z leads are then recorded utilizing CR, CL, and CF positions. Occasionally in certain pathological states a diagonal lead is recorded using Lead II (RA - LF position). Utilizing lead II is a simple matter requiring only the selection of the lead switch since it is evident from figure 1-a that the proper electrode application is already in place.

Thirty-three healthy female student nurses, ages 18 to 20, with no history of cardiac disease were studied in the following manner: A conventional 12 lead electrocardiogram was taken in the sitting position. Vectorcardiograms were then recorded in the frontal, horizontal and sagittal planes together with the respective scalar X - Y - Z components utilizing the cube and this system.

It was immediately apparent that the scalar leads of our system appeared to be of better quality and

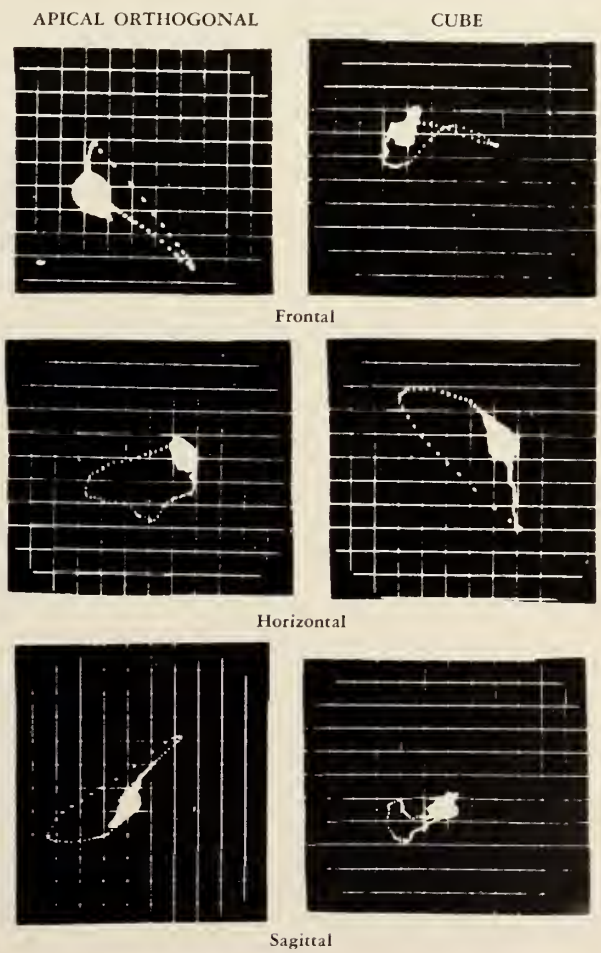



FIG. 2-b. *Comparison of vector loops of the two systems.*

subject to more detailed analysis. Interference was less marked and the curve contours were clearer and of greater voltage. (See example.) There was minimal interference in photographing the loops in the sitting position thereby making it possible to facilitate the examination by the use of suction electrodes.

In conclusion this preliminary report of a simple reproducible apical orthogonal lead system for vectorcardiography is presented. It is believed that this method yields more satisfactory scalar orthogonal leads than does the cube or other related systems. The proximity of the heart in the method augmented by an additional (4th or diagonal) lead may well result in the recording of electrical effects of small pathological lesions which might be obscured or lost by the more distant electrode placement methods. Further studies on normal and pathological states are in progress to determine whether this system may reduce the need for the 12 conventional leads.

Acknowledgment: We would like to acknowledge the cooperation of the St. Elizabeth Hospital School of Nursing in the study. Also, Miss Pat Kennedy, R. N., and Mr. Bob Jones, technician.

Submitted June 30, 1961.

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**THE MEDICAL TREATMENT FOR EPILEPSY** today is effective in the control of seizures in about 60 per cent of cases. The number of seizures in another 25 per cent can be cut down until they are hardly a handicap. In the remaining 15 per cent, the seizures are refractory to all of the available forms of therapy. . . . In many instances patients who have severe, intractable epilepsy (the 15 per cent group) are forced to live a life of invalidism or at least semi-invalidism. For some of these patients institutional care may be the only recourse.

1. It is of utmost importance that treatment be instituted as soon as diagnosis has been established, regardless of the method of therapy employed.

2. Anticonvulsants should be used with the forms of epilepsy for which they are most effective. Phenobarbital and Dilantin,® for example, frequently accentuate petit mal (simple staring) spells. Tridione® increases the frequency of pre-existing major motor seizures and sometimes precipitates them.

3. Treatment should begin with one drug, in the conventional dosage. Dosage should be increased until the convulsions are controlled or until the tolerable maximum has been reached. If maximum tolerable dosage of any anticonvulsant drug reduces the frequency or severity of the seizures to some extent, the drug should be continued. Convulsions can be controlled in many patients with a combination of drugs when the maximum tolerable dosage of any single drug fails. If, however, the maximum tolerable dosage of a drug does not benefit the patient, it should be gradually withdrawn.

4. The effective dosage of anticonvulsant medication varies from patient to patient.

5. Effective medication should be continued with daily administration for at least four years after the last seizure. Children who have had only one seizure of undetermined etiology should also have daily anticonvulsant therapy in full dosage for at least four years. It may be discontinued sooner in patients with petit mal epilepsy.

6. Anticonvulsant medication should be discontinued very gradually. After the four-year period, the dosage should be reduced over approximately one year. Sudden withdrawal of anticonvulsant drugs, especially phenobarbital or Mebaral,® is the most common cause of status epilepticus. If there should be a recurrence of seizures while the dosage is being reduced, dosage should be immediately increased to the original level.

7. Periodic physical examination and at least monthly blood check should be made on patients receiving drugs which are known to have an occasional effect on the hematopoietic system, such as Mesantoin,® Tridione,® Paradione® and Phenurone.® Such drugs should be discontinued immediately if signs or symptoms of hematologic disturbance become manifest. — *Feelings and Their Medical Significance*, 4:2, February, 1962.

# The Jaundiced Newborn

## A Discussion of Etiology and Management

ARTHUR J. NEWMAN, M. D.

THE INFANT who has hyperbilirubinemia runs a serious risk of developing kernicterus. This syndrome of icteric encephalopathy may manifest itself in the newborn period with typical signs of opisthotonus, extensor spasms, tongue protrusion (the so-called adder's tongue), and difficulty in nursing. Even when these symptoms are not present in the newborn period, evidence of kernicterus may be present in the older child or adult who displays the signs of athetosis, rigidity, abnormalities in development of dental enamel, palsy of gaze, especially upward and deafness or auditory aphasia.

With the recognition that elevated levels of indirect reacting bilirubin are seen in situations other than erythroblastosis fetalis and that "physiologic jaundice" is not now sufficient explanation for the development of icterus in a newborn, the management of each icteric newborn becomes a problem in the prevention of kernicterus.

Preparations for the management of the jaundiced child must begin with recognition of causes for the jaundice and elimination wherever possible of iatrogenic factors. In some situations, preparations for exchange transfusions to prevent kernicterus must be accomplished before the birth of the child.

### Metabolism of Bilirubin

There is agreement that indirect reacting or unconjugated bilirubin is a toxic compound. This substance exists in increased concentration when the liver is unable to conjugate the free bilirubin presented to it. There is ample evidence that the enzymatic apparatus of the liver of the newborn, and especially, of the premature, is unable to excrete completely even the normal amount of pigment from the breakdown of red cells.

Free bilirubin which has been released by the action of the reticuloendothelial system is carried in the blood stream, preferentially bound to albumin. It is relatively insoluble in an aqueous medium until converted to a water soluble glucuronide according to the following process:

uridine-diphosphate glucuronic acid + (indirect) bilirubin $\xrightarrow[\text{transferase}]{\text{glucuronyl}}$ (direct) bilirubin glucuronide + uridine-diphosphate.

This function of the liver is performed at less than peak efficiency in the premature, in the newborn period, or under certain adverse situations.

Submitted August 19, 1961.

### *The Author*

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### Increased Production of Bilirubin

Any circumstance resulting in increased hemolysis with subsequent presentation to the liver of increased amounts of bilirubin will increase the likelihood of hyperbilirubinemia. Such situations occur in erythroblastosis fetalis, (whether due to RH or ABO incompatibility), as a result of sepsis due to bacterial invasion, or to parasitic or viral illness as toxoplasmosis or cytomegalic inclusion cell disease. Increased hemolysis may occur also as a result of drug administration either to the mother antenatally, or to the newly born baby. Some of the vitamin K analogues have been incriminated in this regard although they may operate to produce hyperbilirubinemia through another mechanism to be mentioned subsequently. Infantile pyknocytosis has been mentioned as a cause of increased hemolysis as has the rare case of congenital spherocytosis. Blood absorbed from large hematomas, especially cephalhematomas, acts to provide an increased amount of bilirubin for the liver to attempt to excrete.

### Failure of Liver Function

Hyperbilirubinemia may result not only from failure to metabolize an increased amount of bilirubin, but also when a poorly functioning liver is unable to conjugate bibirubin resulting from the normal breakdown of red cells.

Many conditions are believed to play a role in affecting the chemical process of conjugation. It is not unlikely that glucuronyl transferase is a delicate enzyme, and that it may function poorly in all newborns, at least as compared with the older child or adult. Anoxia or hypoxia of the newborn as an intrauterine or postpartum phenomenon is frequently

associated with the development of hyperbilirubinemia. This is particularly true of the premature infants. Certain chemicals, especially in the sulfonamide group, and large doses of vitamin K have been reported to have a hepatotoxic effect. Many drugs are given to the pregnant woman. How toxic they may be to the fetus has not been established.

Hyperbilirubinemia may occur in at least a relative sense in the newborn who becomes excessively dehydrated and hemoconcentrated. This situation occurs from time to time in neonates of diabetic mothers, in prematures, and in children of nursing mothers whose milk supply is slow in being established and who are not given adequate supplemental fluids.

### Effects of Certain Drugs

It has previously been noted that free bilirubin is carried in the serum bound to albumin. Certain drugs —such as sulfisoxazole (Gantrisin®), (Albamycin®), and some of the vitamin K preparations are thought possibly to compete for albumin and by displacing bilirubin, release enough of this compound to produce kernicterus at levels of bilirubin (12 to 15 mg. per 100 cc.) otherwise considered to be in the safe range.

Many other factors affecting the infant's liver such as infectious hepatitis, hypothyroidism in mother or baby, or thyrotoxicosis, genetic influences, or placental dysfunction, also play a part in determining the degree of hyperbilirubinemia.

The point requiring emphasis at this time is that at the present state of our knowledge, any factor or factors working singly or in combination to produce an elevation in unconjugated bilirubin may result in kernicterus.

Elevations in the direct reacting bilirubin which is seen when biliary or intrahepatic obstruction is present is not now believed to cause kernicterus. It is important, therefore, to fractionate the bilirubin into direct and indirect reacting components rather than to subject a baby to the risks of an exchange transfusion because the total bilirubin is elevated.

### Antenatal Precautions

During the antenatal period it is the responsibility of the attending physician to determine not only the Rh grouping of the mother, but her blood type as well.

A mother who has previously received blood transfusions at any time in her life may develop Rh sensitivity and produce an erythroblastotic baby in her first pregnancy. An A-B-O erythroblastotic baby may be seen with any pregnancy.

While the deficiencies of testing for Rh antibodies in the maternal serum during the antenatal course are well known, they can perform a useful function and occasionally warn the physician of impending trouble. The fact that there are false positives and negatives only means that like any other laboratory test it must be evaluated along with the clinical picture.

Drugs given to the mother during pregnancy and especially during labor must be evaluated in terms of possible damage to the fetus. At our present state of knowledge, long active sulfonamides such as sulfamethoxypyridazine (Kynex®), and sulfadimethoxine (Madribon®), are contraindicated for use in the mother during labor. The use of large amounts of vitamin K analogue (Hykinone®), is also contraindicated. A dose of 2.5 mg. will prevent hemorrhagic disease of the newborn without causing the risk of hyperbilirubinemia.

The same caution regarding the use of sulfonamides and vitamin K analogues holds true for use in the newborn and premature who may be extremely sensitive to potentially toxic drugs. Sulfisoxazole (Gantrisin), has been incriminated in the production of kernicterus at low levels of bilirubin in prematures.

To minimize the degree of icterus, it is essential that the newborn, especially if breast-fed, be offered sufficient fluid to avoid hemoconcentration.

### Detection of Hyperbilirubinemia

Thus far we have considered only prophylactic measures to prevent hyperbilirubinemia. Management of the icteric neonatal infant requires a policy of active rather than passive watchfulness. To treat the icteric baby we must first identify him. The nursing staff in the newborn nursery should examine each baby during each shift and notify the responsible physician at once, day or night, in the event that jaundice develops within the first 36 hours of life. Should jaundice develop at a later age the responsible physician should be notified though not as an emergency matter.

The mother's blood type and Rh classification should be placed on the chart of the newborn and particular attention paid to the infant of a mother, who is type O or Rh negative.

Having identified the child who is icteric, it is necessary to quantitate the degree of bilirubinemia. This cannot be done by estimation of the child's appearance. The severely erythroblastotic child does not appear jaundiced at birth although his serum bilirubin may be 8 to 9 mg. per 100 ml. It takes a period of time before the tissues become sufficiently saturated with bilirubin to make him clinically jaundiced. In the less severely affected child also, the skin becomes yellow at a slower rate (and clears at a slower rate) than the rise (or fall) of serum bilirubin.

### Necessity of Accurate Measurement

Since even the most experienced observer cannot make an accurate guess, it is essential that the hospital laboratory be equipped to perform direct and total bilirubin determinations. By subtracting the direct bilirubin reading from the total, the indirect reading, toxic, free bilirubin can be calculated. The performance of repeated venipunctures on a newborn or premature baby is a difficult if not dangerous task and is shunned by all but the most experienced physician. This unfortunate state of affairs need not continue

since an accurate semi-microtechnique for doing bilirubin determinations on blood obtained from a heel puncture has been available for some time. A technician can obtain the blood sample, freeing the physician and making the determination feasible at any hour.

It must be emphasized that even when the laboratory procedure is carried out properly, false readings will be obtained if the blood sample is hemolyzed, if the blood (or possibly even the baby) is exposed to light, or if the baby is moribund. Even under optimal conditions the accuracy of the procedure is probably not greater than to within 2 mg. per 100 cc.

### Investigation of Etiology

Search should be made for the cause of the hyperbilirubinemia. A history should be taken. Cord blood can be used to obtain type, Rh, and Coombs' test on the infant. Determinations of hemoglobin, examination of the blood smear for spherocytes, nucleated red cells and reticulocytes should be accomplished. Blood cultures must be obtained when indicated and the urine examined for inclusion bodies. No one can say with certainty what level of indirect bilirubin is capable of producing kernicterus for any individual infant particularly since levels usually considered safe may be dangerous if the bilirubin is freed from albumin in the serum by the action of certain drugs. In general it can be said that levels in excess of 18 mg. per 100 ml. for prematures and 20 mg. per 100 ml. for full term infants are to be considered dangerous and constitute an indication for prompt treatment in the presence of hemolytic disease. Where no evidence for hemolytic disease is uncovered, a level of 20 mg. per 100 ml. of indirect reacting bilirubin in a premature infant, and 25 mg. per 100 ml. in a full term infant would constitute indication for exchange transfusion.

### Treatment by Exchange Transfusion

The only treatment presently available for hyperbilirubinemia is the performance of one or more exchange transfusions. This procedure is attended with a mortality figure of 2 to 3 per cent, in even the best hands. Frequently, affected infants are transported to a large center for management. It must be emphasized that 10 cc. of clotted maternal blood should accompany any infant so transferred. The only safe cross match in the event of blood group incompatibility is one performed against mother's blood. Even when no apparent incompatibility is present, for instance, when both mother and infant are thought to be Rh positive, actual Rh incompatibility may be present. Testing for Rh as a routine procedure consists of testing for D. If this is present the individual is labeled Rh positive. Not infrequently erythroblastosis due to antibody production against one of the other Rh factors, C., E., c, or e, is seen. Only a cross match against mother's serum would prevent a possibly disastrous outcome. In an emergency, use of the mother's blood would be satisfactory.

### Importance of Hemoglobin Determination

Though not wholly germane to the question of jaundice, the importance of the hemoglobin determination cannot be overemphasized. In severe erythroblastosis a fall in hemoglobin signals sooner than a rising bilirubin, the seriousness of the situation. In the presence of blood group incompatibility and a newborn who displays the clinical signs of severe erythroblastosis — edema, pallor, hepatosplenomegaly, and possibly purpura, a cord blood hemoglobin less than 14 Gm. per 100 cc. should be an immediate indication for exchange transfusion, even prior to obtaining a bilirubin.

Under certain circumstances, such as when a mother has previously delivered an erythroblastotic baby, it would be prudent to have the next baby delivered with fresh blood cross matched and personnel and facilities for doing an exchange transfusion prepared to perform an exchange transfusion within 15 to 30 minutes after birth.

### Summary

Each newborn with icterus presents a problem in diagnosis and therapy. Regardless of etiology, kernicterus may result from hyperbilirubinemia. The physician should be notified of all icteric infants. The degree of jaundice cannot be estimated but must be determined by performing frequent determinations of serum bilirubin. Where dangerous levels of indirect reading of bilirubin are discovered, exchange transfusions with compatible blood must be performed. If a baby is transferred to another hospital for investigation or possible exchange transfusion, it should be accompanied by a sample of the mother's blood.

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SEARCH FOR MECKEL'S DIVERTICULUM, and removal when found, should be a part of every laparotomy unless such search and removal add significantly to the hazard of the operation. — James H. Stewart, M. D., and Clifford F. Storey, M. D.: *Southern Medical Journal,* 55:16-28, January, 1962.

# Primary Sclerosing Cholangitis

## Report of a Case

JEROME H. MEYER, M.D.

PRIMARY sclerosing cholangitis is an uncommon disease of the biliary system. It is, however, one that can be cured once the diagnosis is established. With an increase of over 100 per cent incidence of hepatitis it is imperative that the surgeon as well as the family doctor and internist be aware of its existence. The differentiation of this condition from hepatitis and obstructive jaundice makes the diagnosis imperative because of the response of primary sclerosing cholangitis to combined surgical and medical management. Two factors have aided in the marked decrease in mortality rate of this disease. One is the diagnosis of the disease and institution of surgical drainage, and the other is the use of steroid therapy.

Of the 18 cases reported in the literature since 1958 there have been only three deaths, a marked improvement over the previous 45 per cent death rate. One patient died of cirrhosis after the removal of the "T" tube, probably prematurely. One death was unrelated, and one patient failed to respond to treatment.

McSwain[1] believes this type of biliary disease is not rare but probably has been unrecognized. Therefore, we undertook to examine records of three larger hospitals in the Miami Valley area to determine if the diagnosis had been unrecognized. Eight hundred and ninety-two records, including all records of postmortem examinations, have failed to reveal any case on record aside from the one herein presented.

### Case Report

A 30 year old white woman was admitted to the hospital on April 29, 1958, with jaundice. She complained of malaise, anorexia, nausea and vomiting, and weight loss beginning 10 days prior to admission. Two days prior to admission she noted dark urine and a yellow tinge to her sclera. She had noted pain and tenderness in the right upper quadrant intermittently for one month prior to admission. She had lost 9 lbs. in two weeks.

The *past history* revealed a total hysterectomy in 1956 for uterine bleeding, but she had no transfusions and had received no hypodermic injections or medications recently.

On *physical examination* the only positive findings were jaundice and a liver edge palpable 2 finger breadths below the right costal margin.

*Laboratory findings* were as follows: Total bilirubin was 6.8 mg. per 100 ml. with a direct value of 4.8 mg. The prothrombin time was 70 per cent of normal. Cephalin flocculation test was 4 plus, and the stool was positive for blood. Transaminase levels of 234 and 258 units were recorded.

Submitted July 14, 1961.

### *The Author*

● **Dr. Meyer, Dayton, is Assistant Chief of Surgery, Dayton State Hospital, a member of the staff at Good Samaritan Hospital, and consultant, U. S. Air Force Hospital, Wright Patterson Air Force Base.**

*Treatment* consisted of bed rest, low fat diet, vitamins including vitamin K, intravenous fluids, and antibiotics.

The patient improved slowly, her jaundice decreased, and her prothrombin time improved after having fallen to 60 per cent of normal. The liver tenderness remained but there was no pain. She was discharged on the forty-seventh hospital day (June 15) with the diagnosis of infectious hepatitis.

Second Admission: On August 4, 1958, she was readmitted to the hospital with jaundice, weakness, and abdominal pain. Four days prior to admission, she noted generalized pruritis. Her appetite was good.

*Physical examination* was different in that the liver edge was 4 to 5 finger breadths below the costal margin. Total serum bilirubin was 19.2 mg. per 100 ml. with a direct reading of 12.4 mg. Urine urobilinogen 0.14 mg. for two hours. A liver biopsy on August 28 showed "chronic pericholangitis with early fibrosis. No evidence of marked bile stasis within the bile ducts so this lesion may be intrahepatic in origin."

Conservative management was continued and she was discharged, improved, on September 10, 1958, with the diagnosis of cholangiolitic hepatitis.

Third Admission: She was re-admitted eight days later. Her liver had enlarged to 10 cm. below the xyphoid process and 6 cm. below the right costal margin.

Her white blood cell count was 3,550 per cu. mm. with a left shift. Hypochromia and anisocytosis of red blood cells with a 2,560,000 per cu. mm. count and 9.6 Gm. per 100 ml. of hemoglobin were noted. The prothrombin time fell to 55 per cent of normal after having reached 100 per cent during the prior admission. Urine urobilinogen for a two hour period was 0.02 mg. per 100 ml. Alkaline phosphatase was 21 units. Serum bilirubin rose to 32.8 mg. per 100 ml. and prothrombin time fell to 50 per cent of normal. Her stools were clay colored.

She was given steroids and began to show improvement in two days. The diagnosis of primary sclerosing cholangitis was made, and she was operated upon October 2, 1958. At surgery there was stenosis of the bile ducts through which the smallest probe could not be passed. The duodenum was opened, and the common bile duct was dilated to admit the smallest "T" tube. The gallbladder was removed because of chronic cholecystitis with stones. She was discharged, markedly improved, on October 14.

Fourth Admission: The "T" tube was removed as an out-patient three months after discharge because of recurrent attacks of fever and pain in her abdomen and back. On February 2, 1959, she was again admitted to the hospital

because of recurrence of symptoms. On February 19 the common bile duct was again explored, and a biopsy of the duct showed chronic cholangitis. She was discharged on March 6.

The "T" tube was left in place for six months and the patient was treated with steroids and triple sulfonamide drugs of low dosage. After the removal of the tube, steroids were continued for six months longer. The patient is well and without symptoms at this writing.

## Discussion

Dr. Leon Schiff[2] has informed us that he has never seen a case of proven primary sclerosing cholangitis. Of the two cases he suspected of being primary sclerosing cholangitis both patients subsequently proved to have carcinoma of the bile ducts, one of them three years and the other five years after onset of jaundice. No evidence of carcinoma was found in our patient at surgery, and the disease was confirmed by biopsy.

Primary sclerosing cholangitis[3] has been reported in the literature under the following names: intrahepatic cholangeolitic hepatitis,[1] intrahepatic cholestasis (cholangiolitis),[4] primary stricture of bile ducts,[5] chronic stenosing cholangitis,[6] obliterative cholangitis,[7] and stricture of common bile duct.[8,9]

The signs and symptoms of the 31 reported cases are as follows: pain, 13 cases; jaundice, 31 cases; fever, 2 cases; pruritis, 8 cases; nausea and vomiting, 9 cases; anorexia, 31 cases.

The physical examinations showed hepatomegaly in 14 cases.

The laboratory findings included: Alkaline phosphatase 6-25 Bodansky units; Icterus index elevated up to 40 units; Prothrombin time decreased in four cases; Anemia, two cases; Cholesterol, range 172 to 409 mg. per 100 ml. with normal esters.

The etiology of primary sclerosing cholangitis is not known. Two of Dr. McSwain's[1] patients yielded cultures of *Esch. Coli.* Dr. Schwartz,[3] in a logical discussion, suspects the etiology to be a viral infection with an unusual response. We believe our case would tend to substantiate his suspicions.

The treatment should be surgical exploration of common bile duct, if no response is noted after adequate medical management. Steroids, antibiotics of a broad spectrum, and dehydrocholic acids to thin the bile and produce a greater flow of bile should not be used if obstruction is not relieved by drainage.

The operative findings vary except that a thickened firm bile duct is always present. Drainage of the biliary system should be accomplished. The gallbladder can vary from normal to thickened and may or may not contain stones. The bile in the gallbladder may be normal in amount, decreased, or absent. The liver may be enlarged or cirrhotic.

Whether the gallbladder should be removed has been a matter of opinion. Since the gallbladder cannot be used for anastomosis because the entire biliary tree is involved and since there is stasis of bile in the gallbladder which is conducive to infection and stone formation, it is our belief that the gallbladder should be removed. This also will produce a more constant flow of thin bile.

It is our opinion that the "T" tube should be left in the common bile duct for some six months while steroid therapy is being administered and until the patient can tolerate the tube being clamped off for several months except to be irrigated occasionally to prevent sedimentation from accumulating in the tube.

Primary sclerosing cholangitis shows a preference for men by three to one. It should be suspected when patients with hepatitis fail to respond to medical management. The absence of bile in the urine and the diminution or absence of urobilinogen in the urine may indicate obstructive jaundice or intrahepatic etiology or primary sclerosing cholangitis.

## Summary

This is a case report of a patient with primary sclerosing cholangitis successfully treated by prolonged biliary drainage and adjunctive medical measures. Primary sclerosing cholangitis is a disease of the biliary system, which is probably caused by an unusual reaction to a viral infection producing an inflammatory thickening and fibrosing response of the ductal system with obstruction.

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A PATTERN OF URBAN HISTOPLASMOSIS that includes at least four distinct sources of infection has emerged: visits to farms or prior rural residence; exposure to imported farm soils or manures; exposure in urban structures frequented by birds; and exposure in open urban areas. In each of these forms of exposure, urban infection can be related directly to exposure to sources contaminated with bird excreta. — M. L. Furcolow. M. D., F. E. Tosh, M. D., et al., Kansas City, Kansas: *The New England Journal of Medicine,* 264:1226-1230, June 15, 1961.

# A Clinicopathological Conference

## From The Ohio State University Hospital. Columbus. Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

HORACE B. DAVIDSON, M. D., *President*

### *Presented by*

- James V. Warren, M. D., Columbus, and
- Emmerich von Haam, M. D., Columbus.

Edited by Dr. von Haam.

PRESENTATION OF CASE

THIS 48 year old white male taxi driver was admitted to University Hospital because of increasing shortness of breath. One year prior to admission he began having fatigue and weight loss. Six months prior to admission he had decrease in his appetite, nausea without associated vomiting, and an increase of a nonproductive cough. He became progressively more short of breath to the point that walking across the room was difficult. He was orthopneic and would awaken at night with coughing, a choking sensation, and shortness of breath. Two months prior to admission he had several episodes of blood-streaked sputum but otherwise his cough remained nonproductive. He had had a 100 lb. weight loss during the prior year, from his usual weight of 340 lbs. to his admission weight of 240 lbs. Past medical history and review of systems were noncontributory.

### Physical Examination

Physical examination revealed an obese white man who did not appear to be in severe distress. His blood pressure was 170/110, respiratory rate 20 per minute, pulse rate 112 per minute, temperature 98°F. The skin was warm and smooth; there were no rashes present. There was bilateral exophthalmos, more marked on the right side, with an associated lid lag. No venous distention was present in the neck. The thyroid gland was slightly enlarged. There were fine rales in both lower lung fields, most marked on inspiration. The heart rhythm was regular; the pulmonic second sound was split. The liver edge could be felt 2 fingerbreadths below the right costal margin; no other masses or organs were felt in the abdomen and there was no tenderness. The nail beds were cyanotic with clubbing of the digits. There was no peripheral edema and peripheral pulses were all good. Neurological examination was within normal limits.

### Laboratory Data

On admission the hemoglobin was 14 mg. with a hematocrit of 48 per cent; there were 6200 white blood cells per cubic mm. with a normal differential count. Urinalysis showed a few white blood cells per high powered field. The blood urea nitrogen was 14 mg., the fasting blood sugar 84 mg. per 100 ml. The serum sodium was 148 mEq., potassium 4.9 mEq., chloride 102 mEq., and $CO_2$ combining power 20 mEq. per L. The albumin was 4.2 Gm. per 100 ml. with globulin of 4.5 Gm. Thymol turbidity was 25 units; cholesterol was 165 mg. per 100 ml.; alkaline phosphatase was 8.9 units. Bromsulphalein test showed 22 per cent retention of the dye at the end of 45 minutes. Sputum culture on admission grew out only normal flora. Protein-bound iodine was greater than 20 mcg. per 100 ml. with a simultaneous inorganic iodine of 3 mcg. An electrocardiogram showed right axis deviation, clockwise rotation, incomplete right bundle branch block, and nonspecific myocardial changes.

At the time of admission the chest x-ray showed an enlarged heart with chronic inflammatory changes in both lower lung fields. There was right pleural thickening, and there was a mass occupying the right hilum. Laminagrams shortly after admission showed a multilobulated mass along the right heart border in the mediastinum. Bronchograms of the right side showed no endobronchial obstruction but there was reduction in the volume of the lower and middle lobes on the right side with compensatory emphysematous change in the right upper lobe, and again the mass in the mediastinum was noted. It was the impression of the radiologist that this probably represented mediastinal bronchogenic carcinoma with extrinsic pressure on the right and middle lobe bronchi. An upper gastrointestinal series was normal with the exception of a small hiatus hernia. No apparent extrinsic pressure was being placed on the esophagus by the mediastinal mass. A cholecystogram failed to visualize, and intravenous pyelography showed normal kidneys. Barium enema examination was normal.

Vital capacity was 48 per cent of normal, 1 second

Submitted February 2, 1962.

timed vital capacity was 63 per cent and the maximum breathing capacity was 38 per cent of normal.

### Hospital Course

At the time of admission it was felt that this patient had congestive heart failure possibly secondary to hypertensive heart disease. He was given digitalis and intermittent injections of mercurial diuretics. He sustained a 25 lb. weight loss with no direct correlation with the diuretic therapy. Skin tests showed an area of induration with PPD intermediate, and skin tests to histoplasmin, coccidiomycosis and blastomycosis were negative. After several days' hospitalization the patient was subjectively improved although he continued to have fine rales in both lungs. Approximately one week after admission, casts and protein appeared in his urine but the Bence Jones test was negative. The blood urea nitrogen remained within normal limits. Following the x-ray examination it was felt that this probably represented tumor, but whether primary in the lung or metastatic was not determined.

On the 12th hospital day he had a temperature elevation to 101° and a mildly productive cough with a change to coarser rales in the lower lung fields. His sputum culture remained negative. He continued dyspneic and ran a low-grade fever. A scalene node biopsy showed nonspecific chronic lymphadenitis. He began having episodes of crampy right upper quadrant pain with an associated tender liver which was felt to be due to congestion. His respiratory difficulty continued. On the 18th hospital day he had moist rales over the entire right lung field and the lower one third of the left lung, and was producing thick yellow sputum. During this time his white blood cell count was 15,000 to 16,000. The patient's respiratory difficulty increased, and despite the various therapies continued to have rales in both lung fields. Because of a questionable thyrotoxicosis the patient had been started on propylthiouracil and this was continued for the remanider of his hospitalization. He continued to have episodes of crampy right upper quadrant pain with associated tender liver.

On the 24th hospital day a sputum culture grew out a coagulase-positive *Staphylococcus* and he was started on Declomycin®, 300 mg. four times a day. Because of a suspicion of a malignant disease he was started on Cytoxan®, which he seemed to tolerate well. He became afebrile for four days and his respiratory difficulty seemed to lessen. He continued to have the palpable and enlarged liver and also was noted to have some dependent edema. Blood gas studies showed an arterial oxygen saturation of 53 per cent at rest with a blood pH of 7.48, a $pCO_2$ of 31.7 mm. On effort and breathing 100 per cent oxygen he had an arterial oxygen saturation of 94 per cent, his pH remaining at 7.43, and the $pCO_2$ was 36.4 mm. Hg.

A right thoracotomy with exploration of the mediastinum was carried out and lung, pleura and lymph node biopsies were taken. On the evening following his surgery he again became febrile with a temperature to 102°. A portable x-ray at that time showed no evidence of pneumothorax or pneumonia. His fever continued, and on the day prior to death his temperature reached its maximum height of 105°, at which time his white blood count was 2,000 cells per cu. mm. He became progressively more short of breath and died on the 34th hospital day.

### CLINICAL DISCUSSION

DR. WARREN: This was a man who had multiple system disease and I found it difficult to decide where his trouble had started and just what the nature of it was. He was a 48 year old white taxi driver. This always makes me think of peptic ulcer. He had a history of various complaints: fatigue, weight loss, decrease in appetite, cough, shortness of breath, orthopnea and then episodes of a choking sensation. Later he developed some blood-streaked sputum from his previously nonproductive cough. Then we are told that he had had a 100 lb. weight loss. This might have been pretty staggering had we not been told that he originally weighed 340 lbs. These are the symptoms to a large degree of a debilitating disease, such as cancer or chronic infectious disease especially involving the lung, which would give him the respiratory symptoms. On the other hand, one could choose to interpret these symptoms primarily as a manifestation of cardiovascular disease and of cardiac failure. It is usual to find that a patient with cardiac failure gains weight as he develops failure. However, much of this is recognized as water, and it occasionally happens that the picture presented here develops, a form of cachexia. Some people have given it the name "cardiac cachexia."

The physical examination presented some interesting observations. First of all, his blood pressure of 170/110. One immediately thinks, "Well, this man has severe hypertension." But I would introduce a note of caution. This man was very obese and I would wonder what effect the obesity had on his blood pressure readings. The pulse rate was rapid, and this might have served in part to keep the diastolic pressure up. Had I been doing the examination of this patient I would have looked to the eyegrounds and other areas to try to get support for a diagnosis of hypertensive vascular disease. I gather that his eyegrounds were not particularly remarkable. His eyes were remarkable, however, for exophthalmos, more marked on the right and associated with lid lag. He also had warm, smooth skin and a thyroid that was felt to be slightly enlarged. We will come back to this, but here is the first inkling that maybe this man had the hypermetabolism of thyroid disease. The liver edge was felt, and there was cyanosis but no edema.

The laboratory data showed several interesting

facts which I picked out of a long list. The hematocrit was 48 although his hemoglobin was 14 Gm. One wonders whether or not he had a tendency toward polycythemia. In a debilitated person, it may mean that he was somewhat dehydrated. His renal function was apparently good. Interesting is the group of laboratory findings including an albumin of 4.2, globulin 4.5, thymol turbidity 25 units, cholesterol 163, alkaline phosphatase 8.9 and a 22 per cent BSP retention. I am inclined to add them up to show that he had some disturbance of liver function. The cholesterol may have been influenced by the thyroid status. You note that he had a relatively normal albumin but a high globulin level. Then we find the protein-bound iodine increase, which is another suggestion that his thyroid was not functioning quite properly. I thought I might ask Dr. Ryan if he would like to comment on his electrocardiogram.

### EKG Doesn't Help

Dr. J. M. Ryan: This isn't much help to you. You see an EKG like this with so-called "fat man's disease," hypoventilation syndromes in obesity, but the right axis deviation, incomplete right bundle branch block, and inverted T-waves are nonspecific. I don't think they really are of much help.

Dr. Warren: I agree that one questions whether he had this fat man's syndrome, the Pickwickian syndrome, which is really a form of right heart failure associated with polycythemia and a variety of other findings. I think there are other evidences to show that he did have heart trouble and I think these are not the typical findings of hypertensive vascular disease or of heart failure associated with hyperthyroidism. It looks as though there may be something wrong with his right ventricle. When we come to his x-rays I think it would be more helpful to have Dr. Cook interpret them to us.

### X-Ray: Anterior Mediastinal Tumor

Dr. W. T. Cook: I doubt that his heart is really very big, judging from the left border. The right border is lost in this abnormality here. I would not have suspected that he had incipient heart disease from this chest x-ray. The striking abnormalities are in the mediastinum. I don't think it is an aneurysm of the ascending aorta because it has an irregular border. We know that it is anterior because the space behind the sternum is filled in in the lateral view. The other component in the chest film consists of diffuse infiltration in the right lung, which was more concentrated in the anterior portion of the lung. The major bronchial segments are open, he does not have bronchiectasis that we can appreciate, and in terms of carcinoma nothing definite can be said. It does not look like a carcinoma here. I would base my opinion here on the differentiation of an anterior mediastinal tumor. If you eliminate aneurysm, it boils down to lymphoma, leukemia, and carcinoma, which it certainly could be, and then there are the rarer mediastinal tumors such as a mediastinal mesothelioma. I doubt the latter, however, because they usually spread by pleural involvement and don't involve the lung in this fashion. Lastly, there is chondroma, which would be a pretty good bet. I don't think this is mediastinitis with mediastinal abscess. He had the mediastinal widening when he came in and he did not become febrile until later on in his course.

Dr. Warren: If we try to break this down into categories, we must consider first: Is this a vascular lesion? The evidence is against that and I am inclined to throw that out. As I tried to analyze this I thought we are brought down to two groups of difficulties: Could this be some sort of inflammatory or granulomatous lesion or could this be tumor? In the former we would have to put our old friend tuberculosis, I suppose. Would this be acceptable to you as a sarcoid lesion?

Dr. Cook: No, because he had pleural involvement and in uncomplicated sarcoid you do not have pleural involvement.

### Primary or Secondary?

Dr. Warren: Then we come down to the matter of tumor, and we come down to primary versus secondary. Let's take up secondary first. Could these be metastatic lesions, say from carcinoma of the esophagus or stomach, or kidney?

Dr. Cook: It could be a metastasis from just about anything, but generally speaking, metastases don't tend to go to the anterior mediastinum and produce bulky masses. One of the exceptions would be a testicular tumor, for example, where the primary may be very small and the mediastinal metastasis very large. But this is not the familiar pattern of mediastinal metastasis.

Dr. Warren: Then we get down to primary lesions. First, of course, carcinoma of the lung, and you stated that the x-ray would be compatible with this diagnosis plus seeding out into the right lung field. I am including in my thinking lymphoma which also seeds out into the lung and causes this type of picture. Are there any differential points between let us say lymphoma and carcinoma of the lung as you see these films?

Dr. Cook: It could be a peripheral bronchogenic carcinoma metastasizing to the mediastinum. The film also is highly compatible with lymphoma, but I thought less about that because he did not have the physical signs of lymphoma.

Dr. Warren: His vital capacity indicated that his lungs were not working right. Then later on he was found to have an arterial oxygen saturation of 53 per cent at rest. Interestingly enough, on effort and breathing this went up to 100 per cent. What this means to me is that he had diffusing problems which would fit with a diffuse lesion in the lungs.

But one would wonder how he could have this and a good lung on the left, and it might lead me to feel that perhaps this was involved too. Apparently the people who were taking care of the patient were also confused. They did a variety of other tests. They thought he might have thyrotoxicosis, so they started him on propylthiouracil and that did not seem to help. He had been around the hospital for 24 days and that was long enough to acquire a coagulase-positive *Staphylococcus*. I make nothing more of this than that he was a debilitated person in a hospital environment. Then they decided that maybe this was really a malignant disease and gave him Cytoxan. Finally they went ahead and did a thoracotomy with exploration of the mediastinum and lung, pleura and lymph nodes.

He had several organ systems involved. He apparently had some difficulty with his heart although since I have seen these x-ray films I am a little less impressed by this than I was from reading the protocol. He certainly had profound disease of his lungs, he had disease apparently affecting his metabolism, and he had disease affecting his blood production system which may have been the effect of Cytoxan rather than of his disease. I don't think it is simply a cardiovascular problem.

The x-ray films and the other findings in the chest point to his mediastinal lesion as the basis of his trouble, and here I would have to list several things that we have already gone over: First, could this be a primary tumor in this area such as carcinoma of the lung with local infiltration and then infiltration into the lung fields perhaps causing a degree of cor pulmonale by obstruction to the pulmonary circulation and also causing this difficulty in oxygenation? This I think would have to be a very real possibility on our list. Secondly, could this be a tumor arising in the lymph nodes of the mediastinum, a lymphoma of one sort or another, doing essentially the same thing? I think this is a very good possibility, and these tumors are particularly prone to cause this type of infiltrative lesion and this type of disturbance in the lung. For that reason I like that particular diagnosis. In the third group are the possible tumors elsewhere. Could he have a primary tumor in his thyroid gland with metastasis here? The hyperthyroidism, if it is valid, suggests this. Thymoma is another such possibility.

Dr. Cook: Pulmonary fibrosis could be the main cause of his pulmonary lesion, but I have never seen it associated with mediastinal widening.

Dr. Warren: Do you want to comment on this Dr. Weissler? Were you going to call this alveolar capillary block from the evidence we have here?

Dr. A. M. Weissler: Yes. He responded to oxygen therapy very dramatically. He did not have alveolar hypoventilation, where one would expect an elevated $CO_2$, which he did not have. One thing which causes alveolar capillary block in cancer is a lymphangitic spread of carcinoma. The stomach is a common site for primary tumors which spread into the small lymphatics of the lungs and produce a similar picture. He did have nausea, and his primary complaints other than fatigue and weight loss were appetite loss and nausea, and the big liver which was previously thought to be congestion, in the light of the size of the heart could represent metastatic involvement of the liver as well. I would consider in addition the diagnosis of undetected carcinoma of the stomach with lymphangitic carcinomatosis of the lungs.

Dr. Warren: These are very good points. Well, I feel that this is not a situation in which one should be dogmatic. It is more entertaining to try and stick your neck out, and so I feel my first bet would be a neoplasm in the mediastinal area which infiltrated the lungs and probably involved the heart itself. If you study hearts in patients with neoplastic disease it is surprising how frequently this does occur, and as Dr. Weissler points out, it is very likely that this patient had neoplasm involving the liver also. The question would be, What are the primary sources? So I think I would make lymphoma my first choice, carcinoma of the lung second, and some of these others third and fourth. The tumor then spread and caused alveolar involvement of the lungs and a secondary cor pulmonale type of lesion with obstruction of the pulmonary circulation, which in itself will contribute to some enlargement. I would predict from the EKG and the circumstantial evidence that he will have some enlargement of the right side of the heart. I would be surprised if Dr. von Haam tells us that he had a great thick left ventricle.

Dr. Ryan: Is there any chance of the mediastinal tumor being a fat tumor?

Dr. Warren: In a CPC anything is a chance.

### CLINICAL DIAGNOSIS

1. Mediastinal tumor.
   - (a) Lymphoma.
   - (b) Bronchogenic carcinoma.
   - (c) Metastatic.
2. Cor pulmonale.
3. Congestive heart failure.

### PATHOLOGICAL DIAGNOSIS

1. Lipomata of mediastinum.
2. Severe bilateral pulmonary fibrosis.
3. Cor pulmonale.
4. Congestive heart failure.

### PATHOLOGICAL DISCUSSION

Dr. von Haam: The body was that of a well developed, middle-aged man showing a considerable degree of obesity. There was no pedal edema and the nail beds were rather pale. The anterior mediastinum contained two well encapsulated masses extending from the root of the neck in the midline

downwards and slightly laterally. Multiple sections through these masses revealed lobules of fat with no traces of any lymphoid tissue. The right mass weighed 150 Gm., the left mass weighed 100 Gm. No other tumors or other abnormalities were found in the mediastinum. The heart was enlarged and weighed 450 Gm. Most of the enlargement was due to hypertrophy and dilatation of the right ventricle. It had a thickness of 4 mm. and the right atrium contained a large mural thrombus. Both lungs were heavy and firm. The right lung contained a small abscess at the biopsy site. The bronchi were congested and filled with yellow-brown mucus. Both pulmonary arteries showed many atheromatous plaques. The main branch of the right pulmonary artery was thrombosed and the thrombus extended into almost every secondary branch of the artery. The hilar lymph nodes were not enlarged. The liver showed the gross pattern of congestion, and both kidneys were large and reddish-brown.

### Microscopic Examination

Sections through the heart showed pronounced hypertrophy of the right ventricle with beginning fibrosis. Sections through the tumor masses showed fat tissue surrounded by a thickened and slightly inflamed fibrous capsule. Sections through the lungs showed all stages of pulmonary fibrosis comparable to the Hamman-Rich type. The alveoli were filled with plaques of alveolar cells, many of them of the foamy type, and many eosinophils. In such places there was alveolar hemorrhage with hemosiderin. The alveolar septa showed increasing vascularity and varying stages of fibrosis. Many alveoli were lined with fibrous membranes and filled with cholesterol crystals. Others were lined with bronchiolar epithelium of the cuboidal type. The larger bronchi showed marked thickening of the basal membranes and severe hypertrophy of the smooth muscles. This condition suggested bronchial asthma. The pulmonary vessels showed marked thickening of the walls of the smaller arteries with narrowing of the lumina as we see in pulmonary hypertension. The liver showed acute and chronic congestion. The kidneys showed mild diffuse glomerulosclerosis. Sections through the thyroid showed no evidence of hyperthyroidism.

*In conclusion* I would like to state that the patient had severe bilateral fibrosis of the lungs with pulmonary hypertension and died from cor pulmonale with congestive failure. He also had two large lipomas of the mediastinum, and the question arises as to a probable connection between the two conditions. In discussing the case with Dr. Pratt he referred me to a publication by Dr. Andrews in 1957 relating to five cases with fibrosis of the lungs indistinguishable from the Hamman-Rich type, with compression of the pulmonary veins by benign mediastinal tumors, tumor of the left atrium, and congenital pulmonary stenosis. Andrews suggested this interference with the pulmonary outflow as one possible explanation of this as yet unexplained phenomenon. Read, on the other hand, considers the pulmonary fibrosis of Hamman and Rich as an allergic of immune pathological process and compares it with the lung found in scleroderma or lupus erythematosus. The patient's mediastinum was undoubtedly under increased pressure by these tumor masses, and pressure must have been exerted upon the pulmonary veins for a long time. I thought I would just mention this mechanism pointed out in the article by Andrews as a possible explanation of the events which might have taken place in our case.

### General Discussion

DR. WARREN: Those are the first *fat* red herrings I have ever seen. I have a couple questions. Do you think we could look at the x-rays again? A fat tumor should be less radiopaque than a solid one.

DR. COOK: In the ideal situation this difference can be made out. Here I can't appreciate any difference in density between the tumor and the surrounding structures.

DR. WARREN: My thinking in this is that this patient did have this alveolar capillary block syndrome, and if you see that with a tumor sitting beside the lung the natural path is to relate it to the tumor, and if I were to see this again I would say the same thing again. I would have very serious doubt whether the tumor had anything to do with this Hamman-Rich syndrome of the lungs. If you are thinking in terms of pulmonary venous obstruction, there are so many venous channels there that I can hardly see how a chronic obstructive difficulty could occur, and actually some of the more classical lesions that produce pulmonary vein obstruction are not associated with the Hamman-Rich syndrome, although there is certainly this matter of time. Personally I think it is a very interesting possible correlation but I wonder about it.

DR. VON HAAM: I just quoted this article with those five cases, two of which would fit our situation.

DR. WEISSLER: Maybe we should think about lymphatic obstruction rather than venous obstruction. There seems to be more association with lymphatic obstruction than venous.

DR. VON HAAM: Undoubtedly all lymphatics must have been compressed here.

DR. WARREN: What did the thyroid experts think about his thyroid condition?

DR. COLTMAN: They thought that thyrotoxicosis might be an outside possibility and that is the reason they treated him at this time, but they actually felt that the patient did not have hyperthyroidism.

DR. SASLAW: Why was Cytoxan recommended?

DR. COLTMAN: The hematologists did not feel

that he had a lymphoma or leukemia but they thought it probably represented a bronchogenic carcinoma.

DR. WARREN: I think you have to practice clinical medicine on the basis of statistical odds, and I don't feel too critical of myself or of our Service. I don't think we should criticize the people for trying all these other possibilities.

DR. WEISSLER: There was a strong statement here that led me down the garden path. It says that there was no venous distention present in the neck. On this basis I thought that his hepatomegaly was probably on a tumor basis. He probably did have venous distention but with his fat neck they probably just could not see it.

DR. SASLAW: I think one thing we have learned in this CPC with Dr. von Haam: We always watch for a lot of curve balls and try to be prepared, but he puts in a good "fat" ball once in a while.

### References


1. Andrews, E. C., Jr.: Five Cases of an Undescribed Form of Pulmonary Interstitial Fibrosis Caused by Obstruction of the Pulmonary Veins. Bull. Johns Hopkins Hosp., **100**:28, 1957.
2. Hamman, L., and Rich, A. R.: Acute Interstitial Fibrosis of the Lungs. Bull. Johns Hopkins Hosp., 74:177, 1944.
3. Read, J.: The Pathogenesis of the Hamman-Rich Syndrome. Amer. Rev. Tuberc., 78:353, 1958.


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**WHAT CAN YOU DO FOR YOUR BLIND PATIENTS?** — If your patients are the parents of a blind child, you can direct them to one of the regional workshop meetings where their problems are discussed and beneficial advice and instructions given. This service is free to anyone who has a blind child and will greatly assist the family in achieving the best possible adjustment with the least confusion, pain and unhappiness.

If your patients are indigent and have a blind child or one who is in need of eye care, it is suggested that they be referred to an ophthalmologist. The ophthalmologist will obtain Form P. O. B. 3 from the Services for the Blind, 85 S. Washington Avenue, Columbus, Ohio. On this form, he can request permission for surgery, educational assistance for the patient, home training, talking book, or consultation with a pediatrician, otolaryngologist, neurologist, or others. Prior to doing surgery or obtaining consultation, it is requisite that clearance or written permission be obtained, otherwise payment of fees will not be honored. In all cases, the evaluation of the socio-economic condition of the family is made and only where need is established is the case acceptable and cost underwritten by the State Welfare Department.

For patients of age 21 to 65 years, the procedure is almost the same. However, the ophthalmologist will complete form P. A. 701, which is obtained from the County Welfare Department. When this has been completed, he will return it to the county worker. This is the form which will entitle the needy blind to financial assistance from the State or enable them to request ophthalmic surgery. Once again, the surgeon is cautioned not to send the patient to the hospital until approval has been obtained in writing. Social investigation work takes time on all elective surgery. However, in the case of a true emergency, you are advised to phone CApital 1-4591 in Columbus (State Welfare Department) and ask for the supervisor of medical services for the blind. You will be given seven days hospitalization during which time the socio-economic status will be evaluated to determine whether the family or the State will assume the full cost.

From age 65 on, patients obtain assistance from the Aid to the Aged division of the Welfare Department. The ophthalmologist completes the form P. O.B. 3 for this category, and the patient may derive the benefits previously described.

Vocational Rehabilitation Services for the Blind are available from age 16 to any age considered feasible. This program is concerned with rehabilitation and is not a medical care program. Only when a handicap is proven to be a vocational handicap is service for medical care given.

The fee schedule paid to the physician for the completion of these forms and for surgery accomplished will vary according to the division of service involved. Continuing effort is being made with some progress to correct this variation. With time and patience, perhaps the entire fee schedule can be placed on a more sound and uniform basis.


CLAUDE S. PERRY, M. D.
Staff Ophthalmologist
Ohio Department of Welfare
Division Services for the Blind

# Maternal Deaths Involving Amniotic Fluid Embolus

By the OSMA COMMITTEE ON MATERNAL HEALTH

SUDDEN, unsuspectable death, or abrupt, massive fatal hemorrhage occurring in a parturient patient shakes the stamina of sturdy obstetricians or stuns the young student. Throughout the Ohio Maternal Mortality Study these two catastrophic phenomena appear in connection with amniotic fluid embolism (amniotic fluid infusion). Under primary cause of death the Committee has chosen to place this etiology into separate locations, e. g., (1) associated with hemorrhage (afibrinogenemia), and (2) without hemorrhage, causing sudden death. Three maternal death cases *without* hemorrhage are presented herewith.

## Case No. 348

This patient was a 24 year old white, Para I, abortus I, who died four hours postpartum. The past history indicated that there had been no surgical operations or serious illnesses. At term, she was admitted, in early labor, about 10:00 a.m. December 19. Labor progressed normally. At 12:15 p.m., with cervical dilatation 3 cm., the membranes were ruptured artificially. Medication consisted of 100 mg. Demerol® and 50 mg. Phenergan®, both given intramuscularly. At 3:55 p.m., she was fully dilated and was taken to the delivery room. A saddle block anesthetic was given without difficulty, (time not stated), using 0.8 cc. Cyclaine® given between the third and fourth lumbar vertebrae. A live baby, Apgar 9, weighing 8 lbs. 2½ oz., was delivered with low forceps over an episiotomy.

Suddenly, the patient complained of dyspnea and pain in the chest; soon blood pressure and pulse disappeared. Open cardiac massage was begun within three minutes of onset of symptoms, with prompt endotracheal intubation. Cardiac arrest was confirmed. Intravenous fluids of 1000 cc. glucose and 1 cc. Vasoxyl® were administered. A thoracic surgeon was consulted and intracardiac Adrenalin® was given slowly, using 0.5 cc. in a 1:10,000 solution. Levophed® was injected as 4 cc. in 1000 cc. of solution. Two units of blood were given rapidly through a "cutdown." About an hour after onset of arrest, a fairly forceful beat was observed and after 30 minutes more, the chest was closed. Soon thereafter, the radial pulse became imperceptible. Electrocardiogram showed an occasional QRS complex. Further, Adrenalin was given into the heart through the chest wall with no effect, and the electrocardiogram became isoelectric. Death occurred at 7:50 p.m. An autopsy was performed.

*Pathological Diagnosis:* Amniotic fluid embolus, lungs, acute; severe passive congestion of lungs; passive congestion with marked parenchymal degeneration of liver and kidneys.

### Comment

Again, the Committee felt hampered in the omission of a complete autopsy protocol and certain details in the chronological course of events in the case. Members questioned the indication for amniotomy (station not mentioned). The *level* of anesthesia obtained by the anesthetic agent was not recorded. Further, it seemed that 2 units of whole blood, plus 2 liters of fluid, represented grounds for a tremendous overload in the circulatory system, e. g., the myocardium. By narrow margin, the Committee voted this case a nonpreventable maternal death, unavoidable catastrophe.

## Case No. 367

This patient was an 18 year old white, primigravida, who died at term, undelivered. Her past history was not remarkable; she had had no operations or serious illness. Prenatal care covered 10 visits, beginning in the second month; there were *no* complications. The patient was admitted, 41 weeks gestation, on January 15 at 8:15 p.m. Contractions were mild following admission. The cervix admitted one finger, with presenting part at station minus 2. Amniotomy was done at 10:05 p.m., at which time contractions were two to three minutes apart, moderately strong, cervix 2 to 3 cm., station plus 1. Demerol® 100 mg. and scopolamine gr. 1/150 was administered hypodermically at 10:35 p.m. Contractions became stronger and the patient began to "bear down" at 11:15 p.m., as the vertex began to "crown." Suddenly the patient became cyanotic at 11:38 p.m., and died immediately.

Oxygen was given immediately and a thoracotomy was performed, as cardiac arrest became evident. The exact time interval between cardiac arrest and thoracotomy was not known. Further attempt at resuscitation was abandoned and at 11:45 p.m. a postmortem section was done, delivering a live female infant, weight 8 lbs., requiring oxygen resuscitation. The infant survived. Autopsy permission for the mother was obtained.

*Pathological Diagnosis:* (Incomplete report) Amniotic fluid pulmonary embolism; (accidental) perforation, myocardium of ventricle.

### Comment

The sweeping series of events occurring in the brief labor of this primigravida was reviewed by the Committee in a sense of awe. Several members wondered why amniotomy was performed with the cervix 2 to 3 cm. dilated. Again, members regretted that a complete autopsy protocol was not on hand for additional study, and further deliberation. Based on the

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

information available, the Committee voted this case a nonpreventable maternal death, unavoidable catastrophe.

### Case No. 398

This was a 31 year old white, gravida II, Para I, who died undelivered at term. She had had a normal pregnancy and delivery of a 9 lb. baby six years before, after nine hours of labor. There had been a dilatation and curettage during a sterility evaluation since delivery, and a remote tonsillectomy and adenoidectomy. The second pregnancy had been uneventful with adequate prenatal care by her physician. Edema of the ankles necessitated diuretics at 39 weeks, total weight gain being 24 lbs. Apprehension was treated by an occasional dose of reserpine. No hypertension or proteinuria was recorded. It was noted that the patient was unduly alarmed about labor and delivery. On advice of her physician, the night before admission, she took castor oil and began having cramps at 9 a.m., December 12.

On admission, the fetal heart rate was 140 per minute, membranes were intact, cervix was 1 cm. dilated and 30 per cent effaced, vertex was presenting at minus 1 station. Contractions were mild and about every five minutes. She was given 100 mg. of Demerol® at 10:45 a.m. Membranes ruptured *spontaneously* at 11:00 a.m., producing a meconium-stained fluid. Within two minutes, she had a choking sensation and went into a generalized tetanic contraction lasting 15 seconds. Soon, she became coherent, but in half a minute she convulsed again. This second seizure produced a more rigid type of general tetanic contracture, the patient gasping and gagging severely. A promptly performed rectal examination revealed little change in the cervix and station.

A team of anesthesiologists was summoned promptly and performed artificial respiration and thoracotomy for cardiac massage. These proved to be futile. Because vaginal delivery was not possible, a quick cesarean section was done, delivering a live baby weighing 8 lbs. The infant's airways were cleared of debris, and soon it breathed regularly. The clinical impression was amniotic fluid embolism, with the possibility of cerebrovascular accident. All the dramatic events listed occurred within eight or nine minutes. Autopsy examination was permitted.

*Pathological Diagnosis:* Amniotic fluid embolism (amniotic fluid, desquamated skin material seen in pulmonary blood vessels); pulmonary atelectasis; postpartum uterus. (Meninges, spinal fluid and brain not remarkable.)

### Comment

Members of the Committee rejoiced in reviewing data in a case which was compiled so completely, including an autopsy protocol. It was quite obvious that the patient received care within the scope of ideal, as the tragic course of clinical events quickly appeared. Members noted also that the amnion ruptured *spontaneously* in this patient, after which convulsions and pulmonary embarrassment were soon followed by death. Again, the autopsy findings confirmed the clinical diagnosis; heroic treatment proved futile. The Committee voted this a nonpreventable maternal death, unavoidable catastrophe.

### Comment of Consultant

The following comment of a consultant, who is a specialist in pathology, was furnished at the request of the Committee:

"The three cases reported are all very striking examples of the type of catastrophe caused by amniotic fluid embolization. Since its mechanism was shown in 1941,[1] information has continued to accumulate, our experience has widened,[2] but we have to admit that our understanding is still far from perfect, and our methods of treatment are purely empirical and highly ineffective. In fact, there is little cause for complacency, or even optimism, as far as this disease is concerned. However, the prognosis for the fetus is much better than for the mother.[3]

"While it is correct that the syndrome commonly follows very hard or tetanic uterine contractions, it is certainly not necessary for these to be present (as the cases reported above indicate). This complication has even been reported with elective cesarean section, which maks the explanation of amniotic fluid being driven into veins by uterine contractions rather difficult to accept in full. It is also true that many cases have followed the indiscriminate and often unjustified use of Pitocin® but here also there is no constant relationship.

"The clinical manifestations of this disease mimic very closely those of massive pulmonary embolism including even the lack of response to treatment, aimed at stimulating cardiac function and improving oxygenation. The absence in most cases of definite vascular obstruction by thrombus has led to the belief that the condition is basically either an anaphylactoid type of reaction or complex neurovascular reflex. In favor of an immunologic mechanism is the fact that the disease is rarely, if ever, seen in the first pregnancy.

"This syndrome is widely accepted as occurring in a sublethal form but as reflection will soon show, it should be extremely difficult to demonstrate that this has in fact occurred, since the only proof of the disease is the demonstration of amniotic fluid, meconium and squames in the pulmonary vascular tree. It is also accepted that this syndrome is one cause (but certainly not the only cause) of the dangerous hemorrhagic syndrome related to deficiency or absence of fibrinogen. This aspect of the disease can be treated by fibrinogen replacement but the considerable danger of hepatitis from this product should not be ignored.

"The only hopeful development, which is, however, in the research stage, is a compound called Epsilon Amnio Caproic Acid. This is a specific inhibitor of plasma fibrinolysin, and a few cases that have been treated seem to have responded very well. But more experience is necessary.

### Summary

"In summary therefore, this disease comes as a bolt from the blue and other than avoiding the unintelligent use of Pitocin, and sedating the grossly over-contracting uterus, there seems to be little that can be done, either to avoid, or to treat, this disasterous complication of labor."

### References


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2. Nickerson, D. A. Amniotic Fluid Embolism. J. A. M. A., 178:758-759 (1961).

3. Barno, A., and Freeman, D. W.: Amniotic Fluid Embolism. Am. J. Obst. & Gynec., 77:1199-1210. (Includes a discussion of afibrinogenemia.)




# NEWS AND Organization Section

# Medical School Development in Ohio...

## Report Deals with Current Capacity of Ohio Medical Schools. Expansion Plans and Estimated Future Needs

ADDITIONAL medical education facilities are needed in Ohio and immediate consideration should be given to the development of two new medical schools in the opinion of a consultant to the Ohio Commission on Education Beyond the High School which will consider the consultant's recommendations when preparing its final report.

As consultant to the Commission, John W. Patterson, M. D., Ph. D., Vice-Chancellor for Medical Affairs and Dean of the School of Medicine at Vanderbilt University, Nashville, Tennessee, reported on the "medical education facilities needed in the state of Ohio, possibilities for expansion in existing Ohio medical schools, and possible locations for new medical schools."

Dr. Patterson was retained as consultant as a result of action of the 103rd Ohio General Assembly which enacted legislation which authorized the Governor to provide for a survey of current medical education in Ohio. The purposes of this survey are to evaluate the need for additional medical educational facilities and to weigh the necessity and desirability of establishing new medical colleges in Ohio. The Interim Commission on Education Beyond the High School was requested to undertake the study.

### Medical Panel To Make Check

The Patterson report, "A Study of the Medical Education Facility Needs of the State of Ohio," will be reviewed by the Interim Commission, by institutions and communities interested in the medical education facilities of the State, and by a panel of three medical educators who "will have an opportunity to visit selected places in the State and make specific recommendations as directed by the Commission." This panel of medical educators will consist of, tentatively, Dr. Gordon H. Scott, dean and vice-president for medical college development at Wayne State University in Detroit, Michigan, Dr. John B. Truslow, executive dean and director of the School of Medicine at the University of Texas in Galveston, and Dr. Patterson.

In the first section of the report, dealing with "needed facilities," Dr. Patterson summarizes:

### Current Outlook

"The State of Ohio now has three medical schools. On the basis of current programs, they may be expected to enroll about 330 freshman students and graduate approximately 310 students per year.

"On the basis of a national study conducted for the Surgeon General by a committee under the chairmanship of Dr. Bane; on the basis of a proration of the national medical education needs in accord with the population of Ohio; and on the basis of the number of Ohio residents entering the freshman classes of medical schools; the State of Ohio should now have in existence medical education facilities that would permit 440 students to enter medical

school each year. At the present time, Ohio has a deficit of approximately 100 places per class.

"On the basis of similar considerations, population studies, and with the extrapolation of needs to 1975, Ohio needs medical education facilities that will permit approximately 600 students to enter medical school in 1971. With an expected attrition rate of 10 per cent, this will provide 540 graduates in 1975. Unless new facilities are developed, there will be a deficit in each class of approximately 270 places by 1975.

"On the basis of the relative deficiency of physicians in most of the counties of Ohio; on the basis of the relative wealth of the state; on the basis of the time that is required before facilities can be constructed and physicians prepared for the practice of medicine; and on the basis of the need for additional facilities; a decision should be made in the near future to develop additional facilities for medical education in the State of Ohio."

Concerning "expansion possibilities," Dr. Patterson commented:

### Present Expansion Plans

"In considering their programs for the next 15 years, the three medical schools in Ohio have limited plans for expansion. The limits of this expansion provide for entering classes of 200 at Ohio State University and 100 each at the University of Cincinnati and Western Reserve University. This makes a total of 400 places for medical students in the entering class.

"Based on previous considerations which concluded that the number of places needed in the entering class of 1971 is 600, the plans for expansion in the existing schools leaves a net deficit of 200 places.

### Need for New Schools

"Inasmuch as expansion of the existing schools will not take care of the needs of the State of Ohio for medical education facilities, the State of Ohio needs to build new medical schools. Based on an average enrollment of 100 students per class, immediate consideration needs to be given to the development of two new medical schools.

"Inasmuch as new schools need to be developed in Ohio, and inasmuch as expansion programs should be undertaken in a manner which will meet the quantitative needs without neglecting quality, expansion programs in the existing schools should be correlated with the development of new schools."

### Locations Considered

In dealing with the problem of "possible location" of new facilities, Dr. Patterson's report said:

"The assets of the various communities which have been considered as a possible location for a new medical school may be summarized in the form of a table which indicates the relative value of a particular component with a score varying between 1 and 4 plus. This is done in the accompanying table. There is no single community that has a perfect evaluation in all components.

"Therefore, the total number of plus evaluations does not necessarily provide a basis for comparing different localities. The determination of the best site for the location of a new medical school should be based on the judgment of experienced medical educators. For this reason, the recommendation of a specific site or sites is being postponed until (a) this report is made available to all of those who may be concerned, and (b) until a panel of three medical educators has an opportunity to visit the most likely sites. Places suggested for visitation by the panel are: Cleveland, including the Cleveland Metropolitan General Hospital; Akron, including Kent State University; Toledo; Dayton; and Ohio State University in Columbus."

Although the Patterson report contains some detailed data which are pertinent to the three considerations cited in the opening paragraph, specific recommendations are, for the most part, postponed awaiting further study by the panel of medical educators referred to in the report.

*Available Assets For New Medical School Development*

| *City* | *Interest* | *Population Base* | *Site* | *University Base* | *Finances* | *Staff Patients* |
|---|---|---|---|---|---|---|
| Akron | ++++ | +++- | | ++ | — | - |
| Athens | ++ | + | ++++ | ++ | — | — |
| Bowling Green | — | — | ++++ | ++ | — | — |
| Cleveland | ++++ | ++++ | +++ | + | ++ | ++++ |
| Dayton | ++++ | ++++ | — | — | — | ++ |
| Kent | ++ | ++++ | ++++ | ++ | — | — |
| Oxford | — | — | ++++ | ++ | — | — |
| Toledo | ++++ | ++++ | — | ++ | — | ++ |

# Annual Meeting Guest Speakers . . .

## Outstanding Physicians from Other States To Take Part in OSMA Program. in Columbus, May 14-18

AN OPPORTUNITY for Ohio physicians to hear presentations by 20 outstanding guest physicians will be offered in Columbus the week of May 14 at the 1962 Annual Meeting of the Ohio State Medical Association. The following brief sketches are given to identify the speaker and to give his subject and the time of his talk or discussion.

Details of the Annual Meeting program were published in the March issue of *The Journal*. The reader is referred to pages 323 to 350 of that issue.

An innovation of this year's meeting is the slight change in the daily schedule of events. The Scientific program begins on Wednesday, May 16, and runs through Friday. The House of Delegates meets on Monday evening, May 14, and Wednesday afternoon, with House Resolutions Committees meeting on Tuesday. Many Specialty Societies are sponsoring or co-sponsoring programs on Wednesday, Thursday and Friday. Two organizations are holding programs on Saturday. Refer to Page 342 of the March issue for a summary of these events. The President's Ball, leading social event of the Annual Meeting, is on Wednesday.

Following are the Guest Speakers with time of talk and subject of discussion:



Orville T. Bailey, M. D.
Chicago, Ill.

**Orville T. Bailey,** M. D., Chicago, professor of neurology, University of Illinois College of Medicine, will present the subject, "Tissue Reactions to Ionizing Irradiation in the Central Nervous System," at 1:30 p. m. on Friday, May 18, during the program on Pathology. He also will preside at a Slide Seminar following his talk.



Andrew L. Banyai, M. D.
Chicago, Ill.

**Andrew L. Banyai,** M. D., Chicago, emeritus clinical professor of medicine, Marquette University, will be moderator of a panel discussion entitled "Management of the Cardiopulmonary Cripple," at 7:00 p. m. on Thursday, May 17, during the session jointly sponsored by the OSMA and the Ohio Chapter of the American College of Chest Physicians. (This part of the program is in the Neil House.)



H. D. Bruner, M. D.
Washington, D. C.

**Frank Batley,** M. B., Ch. B., Syracuse, N. Y., associate professor of radiology, Upstate University of New York, will participate in a panel discussion on "Practical Problems in the Management of Cancer," at 3:30 on Wednesday afternoon, May 16, during the program sponsored by the Ohio Division of the American Cancer Society.

**H. D. Bruner,** M. D., Washington, D. C., assistant director for medical and health research, Division of Biology and Medicine, U. S. Atomic Energy Division, will discuss "Radiation Hazards" at 11:30 a. m. on Friday, May 18, in the General Session.



Frank Batley, M. D.
Syracuse, N. Y.

**Howard B. Burchell,** M. D., Rochester, Minn., professor of medicine, Mayo Clinic and Foundation, will give the Rudolph Allen Gerlinger Memorial Lecture on the subject, "Changing Concepts of Pericarditis; Acute and Chronic," at 9:30 a. m., on



Howard B. Burchell, M. D.
Rochester, Minn.



Stafan S. Fajans, M. D.
Ann Arbor, Mich.



Jules Hirsch, M. D.
New York, N. Y.



Calvin T. Klopp, M. D.
Washington, D. C.

Wednesday, May 16, during the program sponsored by the Ohio State Heart Association.

**Arthur C. DeGraff,** M. D., New York City, Samuel A. Brown Professor of Therapeutics, New York University College of Medicine, will speak on the subject, "Some Important Aspects of the Newer Drugs," at 11:00 a. m. on Friday, May 18, during the General Session.

**Stefan S. Fajans,** M. D., Ann Arbor, Mich., professor of internal medicine, Division of Endocrinology and Metabolism and the Metabolic Research Unit, University of Michigan Medical School, will talk on the subject, "Aids in the Differential Diagnosis of Spontaneous Hypoglycemia," at 2:00 o'clock Thursday afternoon, May 17, during the program jointly sponsored by the Section on Internal Medicine and the Ohio Society of Internal Medicine.

**William C. Frayer,** M. D., Philadelphia, Pa., assistant professor of ophthalmology, University of Pennsylvania School of Medicine, will speak on "Extraction of Cataracts of Soft Lenses," at 2:00 p. m. on Thursday, May 17, during the program jointly sponsored by the Section on Ophthalmology and the Ohio Ophthalmological Society.

**Jules Hirsch,** M. D., New York City, associate professor, physician to the hospital, Rockefeller Institute and Hospital, will present a paper entitled "Studies on the Dietary Management of Serum Lipid Disorders," at 3:30 p. m. on Thursday, May 17, in the session jointly sponsored by the Section on Internal Medicine and the Ohio Society of Internal Medicine.

**Robert B. King,** M. D., Syracuse, N. Y., professor, Department of Neurosurgery, State University of New York Upstate Medical Center, will speak on the subject, "Physiology and Pharmacology of the Tic Douloureux," on Thursday, May 17, at 3:30 p. m. during the program jointly sponsored by the Section on Neurological Surgery and the Ohio Neurosurgical Society.

**Calvin T. Klopp,** M. D., Washington, D. C., Warwick Professor of Surgery (Cancer), George Washington University School of Medicine, will participate in a panel discussion on "Practical Problems in the Management of Cancer," at 3:30 p. m. on Wednesday afternoon, May 16, during the program conducted by the Ohio Division of the American Cancer Society.

**Edwin R. Levine,** M. D., Chicago, assistant professor of clinical medicine, Chicago Medical School, will participate in the panel discussion on "Management of the Cardiopulmonary Cripple," at 7:00 p. m. during the program jointly sponsored by the OSMA and the Ohio Chapter of the American College of Chest Physicians. He also will participate in the Fireside Conference on Cardiorespiratory Diseases entitled "Chronic Bronchitis and Emphysema," at 8:00 p. m. (These features of the program are in the Neil House.)

**John G. Masterson,** M. D., Brooklyn, N. Y., associate professor of obstetrics and gynecology, Medical College State University of New York, Downstate



Arthur C. DeGraff, M. D.
New York City



William C. Frayer, M. D.
Philadelphia, Pa.



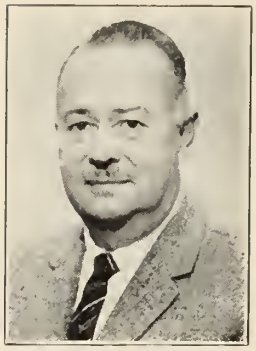
Robt. B. King, M. D.
Syracuse, N. Y.



Edwin R. Levine, M. D.
Chicago, Ill.



John G. Masterson, M. D.
Brooklyn, N. Y.



Arthur K. Peterson, M. D.
Chicago, Ill.



Juan M. Taveras, M. D.
New York, N. Y.



Jerome A. Urban, M. D.
New York, N. Y.

Medical Center, will participate in the panel discussion on "Practical Problems in the Management of Cancer," during the session sponsored by the Ohio Division of the American Cancer Society," at 3:30 p. m. on Wednesday afternoon, May 16.

**George E. Moore**, M. D., Buffalo, N. Y., director of the Roswell Park Memorial Institute, will be moderator of a panel on "Practical Problems in the Management of Cancer," during the session sponsored by the Ohio Division of the American Cancer Society beginning at 3:30 p. m. on Wednesday afternoon, May 16.

**Arthur K. Peterson**, M. D., Chicago, medical director, R. R. Donnelley & Sons Company, will speak on the subject, "Returning to Work after a Stroke," at 4:00 p. m. on Friday, May 18, during the program sponsored jointly by the Sections on General Practice of Medicine, Occupational Medicine, Physical Medicine, and Radiology, and the Ohio Society of Physical Medicine and Rehabilitation.

**A. E. Rakoff**, M. D., Philadelphia, Pa., professor of gynecologic endocrinology, Jefferson Medical College of Philadelphia, will speak on the subject, "Use of Cortico-Steroids in Clinical Obstetrics and Gynecology," at 2:00 p. m. on Thursday, May 17, in the program of the Section on Obstetrics and Gynecology, and will moderate a symposium entitled "How We Manage It," at 3:30 p. m. in the same session.

**Juan M. Traveras**, M. D., New York, professor of radiology, Columbia University College of Physicians and Surgeons, will speak on the subject, "Roentgenologic Diagnosis of Cerebral Vascular Lesions," at 2:30 p. m. on Friday, May 18, during the session jointly sponsored by the Sections on General Practice of Medicine, Occupational Medicine, Physical Medicine, and Radiology and the Ohio Society of Physical Medicine and Rehabilitation.

**Jerome S. Tobis**, M. D., New York City, chief, Division of Rehabilitation Medicine, Montefiore Hospital, will speak on the subject, "Rehabilitation of the Hemiplegic," at 3:30 p. m. on Friday, May 18, during the session sponsored jointly by the Sections of General Practice of Medicine, Occupational Medicine, Physical Medicine, and Radiology and the Ohio Society of Physical Medicine and Rehabilitation.

**Jerome A. Urban**, M. D., New York City, associate attending surgeon, Memorial Sloan-Kettering Cancer Center, co-speaker with Dr. George Crile, Jr., on the subject "The Conservative vs. the Radical Approach to Cancer of the Breast," at 2:15 p. m. on Wednesday, May 16, during the program sponsored by the Ohio Division of the American Cancer Society.

**Philip D. Wilson**, M. D., New York City, director of research, and surgeon-in-chief emeritus, Hospital for Special Surgery, will speak on the subject, "Salvage of the Unsatisfactory Prosthetic Hip," on Friday, May 18, at 2:25 p. m. during the session jointly sponsored by the Section on Orthopaedic Surgery and the Ohio Orthopaedic Society.



George E. Moore, M. D.
Buffalo, N. Y.



A. E. Rakoff, M. D.
Philadelphia, Pa.



Jerome S. Tobis, M. D.
New York City



Philip D. Wilson, M. D.
New York, N. Y.

# Will Entertain at PRESIDENT'S BALL



**Here is the Buckeye Chorus of the SPEBSQSA — the Society for the Preservation and Encouragement of Barber Shop Quartet Singing in America — which will entertain at the President's Ball, Wednesday evening, May 16, Neil House Ballroom. This is one of the top-flight choruses in the nation.**

OSMA Members, their Wives and Friends are cordially invited to gather in the Junior Ballroom of the Neil House at 6:30 p. m. on Wednesday, May 16 for cocktails, after which they will adjourn to the Grand Ballroom for a Buffet Dinner Dance, followed by entertainment and an evening of dancing. Ticket covers the cost of cocktails, dinner, entertainment and dancing. A Dutch treat bar will be available during the period of dancing.



**You can order your PRESIDENT'S BALL TICKETS on this coupon**

**ORDER FOR TICKETS FOR OHIO STATE MEDICAL ASSOCIATION PRESIDENT'S BALL**

*Neil House, Columbus . . . . . May 16, 6:30 p. m.*

Send me.....tickets at a cost of $12.50 per person for the President's Ball, Ohio State Medical Association Annual Meeting, Columbus. Price covers costs of cocktails, dinner, entertainment, and dancing.

(Check, payable to Ohio State Medical Association, 79 E. State St., Columbus 15, for total cost of tickets ordered, must be enclosed.)

Name: (Please Print) .....

Street:..... City and Zone:.....

BE SURE YOUR NAME IS FILLED IN BEFORE MAILING BLANK

# Resolutions To Be Considered at 1962 Annual Meeting

HERE are texts of resolutions which will be introduced for consideration by the House of Delegates of the Ohio State Medical Association at the 1962 Annual Meeting, May 14-18, Columbus.

These resolutions were submitted to the Columbus Office on or before March 15 to comply with the Constitution and By-Laws which states that a resolution which is not in the hands of the Executive Secretary at least 60 days prior to the first session of the House of Delegates cannot be introduced unless it receives at least a two-thirds consent vote by the House of Delegates.

Copies of all resolutions presented to the Columbus Office will be sent to individual delegates so they may discuss them with their county medical societies if they care to do so.

A resolution to be considered by the House of Delegates must be typed in triplicate; introduced by a delegate or his duly accredited alternate seated in his place; and introduced at the first session of the House of Delegates. This procedure must be followed even though the resolution may have been published in *The Journal* or sent in writing to all delegates prior to the meeting.

Sessions of the House of Delegates will be as follows: First Session, Monday, May 14, 6:00 P.M. EST, Grand Ballroom, Neil House. Second Session, Wednesday, May 16, 3:00 P.M., Grand Ballroom, Neil House. Sessions of the Reference Committees on Resolutions will be held all day on Tuesday, May 15, at the Neil House.

## AAPS Essay Contest

(By Charles W. Pavey, M. D., Delegate from Franklin County)

BE IT RESOLVED, That the Ohio State Medical Association again renew its endorsement of the Essay Contest of The Association of American Physicians and Surgeons with the titles 1) The Advantages of The American System of Free Enterprise or 2) The Advantages of Private Medical Care.

## The Dignity of Medicine

(By the Delegates from Allen County)

WHEREAS, The American College of Surgeons has vilified, maligned, and castigated other segments of medicine through articles and statements prepared for and inserted in the lay press, and

WHEREAS, These defamatory statements have lowered the status of the practitioner of Medicine including the members of the American College of Surgeons in the eyes of the lay public, and

WHEREAS, Organized medicine is composed of many units, each with equal responsibility, to the parent organization, the American Medical Association, and to the individual practitioner of medicine, therefore

BE IT RESOLVED, That we the members of the Lima and Allen County Academy of Medicine do view these matters with concern, and

BE IT RESOLVED, That no subdivision within the total organization of the American Medical Association, representing only a segment of Medicine assume prerogatives normally the responsibility of the total organization, and

BE IT RESOLVED, That the House of Delegates of the American Medical Association be urged to censure the offending organization, the American College of Surgeons, for its utter disregard for the welfare of the medical profession and its extreme disservice to the profession, and

BE IT RESOLVED, That the House of Delegates of the American Medical Association be urged to give notice to surgeons of the gravity of their conduct and further apprise them of the fact that their conduct has degraded and maligned the offender equally and has caused organized medicine to be viewed in the eyes of the public in a disgraceful manner, and

BE IT RESOLVED, That the American Medical Association be urged to take upon itself the moral responsibility of upholding the dignity of the profession of medicine as a whole and that it take forthright action in dealing with any segments of the profession acting contrary to the interests of the profession as a whole, and

BE IT RESOLVED, That the delegates and alternates to the American Medical Association from the State of Ohio actively support the censure of the American College of Surgeons and support any activity to correct the situation.

## Use of the Term "Center" For Physicians' Offices

(By the Delegate from Clermont County)

WHEREAS, The assuming of a name for the offices of a Doctor of Medicine or a group of Doctors of Medicine has for its purpose, publicity, the intent of which is not always in the best interests of the public or of other Doctors of Medicine; and

WHEREAS, The use of a geographic location such as the name of a town or village usurps such name and falsely indicates to the laity a type of community enterprise, and implies also a town proprietorship on the part of the doctor or doctors involved; and

WHEREAS, The use of the word "CENTER" implies that other Doctors of Medicine who practice in the town or area are on the fringes, professionally; and

WHEREAS, The combination of the name of the town and the word "CENTER" is particularly revolting to the other Doctors of Medicine who practice in the same area; now therefore,

BE IT RESOLVED, That the Clermont County Medical Society considers it to be unethical for a Doctor of Medicine or a group of Doctors of Medicine to use the name of a geographic location or the word "CENTER" in connection with their office or offices; and further,

BE IT RESOLVED, That this resolution be presented

to the house of Delegates of the Ohio State Medical Association at the annual meeting at Columbus, Ohio on 14 May 1962, for incorporation in the By-Laws of the Ohio State Medical Association.

## Revision of the Council on Medical Education and Hospitals

(By the Delegates from the Academy of Medicine of Cleveland and Cuyahoga County Medical Society)

WHEREAS, Undergraduate Medical Education is a logical function of Medical Schools, and Graduate Training in Medical Specialties is a logical function of Hospitals, and

WHEREAS, These functions, although of two different levels of medical education, are now governed by one American Medical Association Council which "establishes and enforces standards"—The Council on Medical Education and Hospitals, and

WHEREAS, That Council as a result carries a tremendous load covering almost the entire spectrum of medical education and hospitals (22 sub-committees), now therefore,

BE IT RESOLVED, That the Ohio State Medical Association sponsor through its delegation to the American Medical Association House of Delegates the creation of two councils to replace the present Council on Medical Education and Hospitals—these to be known as (1) The Council on Undergraduate Medical Education and (2) The Council on Graduate Medical Education—each to have functions logically falling within the areas described in the title, and further,

BE IT RESOLVED, That each of the Councils should consist of ten members plus staff. The membership of the Council on Undergraduate Medical Education should consist of no more than eight members of medical school faculties and the membership of the Council on Graduate Medical Education should consist of no more than four members of medical school faculties.

## Inclusion of Laboratory Services Under Blue Shield Contracts

(By the Delegates from the Academy of Medicine of Cleveland and Cuyahoga County Medical Society)

WHEREAS, The House of Delegates of the American Medical Association has repeatedly stated that the practice of pathology is the practice of medicine, and

WHEREAS, The guides for physicians in relationship with hospitals state: "If hospital service is limited to include only hospital room accommodations such as bed, board, operating room fees, medicines, surgical dressings and general nursing care, the distinction between hospital and medical services will be clear," and

WHEREAS, The Council on Medical Services of the American Medical Association and its Committee on Insurance and Prepaid Plans have expressed concern over the lack of transfers of such professional services into professional care plans (Blue Shield), now therefore,

BE IT RESOLVED, That the Ohio Medical Indemnity, Inc. (Blue Shield) be urged by the Ohio State Medical Association to develop plans and mechanisms to assimilate these professional services, and further,

BE IT RESOLVED, That the Ohio Medical Indemnity, Inc. restore the laboratory services recently deleted from its contracts and to expand further out-patient laboratory coverage.

## Driver's Training Courses and Physical Examinations for Automobile Drivers

(By the Delegates from the Academy of Medicine of Cleveland and Cuyahoga County Medical Society)

WHEREAS, Traffic accidents have become the most important health problem of the nation, with 40,000 deaths and 1,350,000 injured annually, and

WHEREAS, Accidents occur through combinations of circumstances involving three variables: The driver, the vehicle, and the environment, and

WHEREAS, It has been shown that accident rates for trained drivers are half those of drivers without formal training (McFarland, R. A., and Moore, R. C., *New England Journal of Medicine,* 1957), and that numerous accidents occur because of serious physical disabilities which are more prone to occur with advancing years, and

WHEREAS, Driving an automobile is not an inalienable right, but rather a privilege based on fitness, ability, and other criteria; now therefore,

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association recommends:

1. That the completion of a driver's training course be required for licensure of all new drivers, and

2. That physical examinations initially and at specific intervals be required in the issuance and reissuance of drivers licenses. The standard medical evaluation form as recommended by the Traffic Safety Committee of the Ohio State Medical Association should be completed by the applicant's personal physician for this purpose. Regional medical review boards should be established to hear and rule on appeals in cases involving physical or mental disability.

## Request to American Medical Association On Public Relations Items

(By the Delegates from the Academy of Medicine of Cincinnati and Hamilton County)

WHEREAS, Medical matters in the lay press are frequently releases from national news wires; and

WHEREAS, These releases are frequently with emotional appeal which are detrimental to the entire medical profession; and

WHEREAS, These news releases have not been cleared by the local medical society and the circumstances investigated to determine the validity of the news material; and

WHEREAS, The American Medical Association has in the past referred the investigation of these matters to the local medical society AFTER the news releases have appeared in the lay press; and

WHEREAS, The local medical society has no facilities to clear these matters released by national wire services before the release; and

WHEREAS, The American Medical Association has the National Communications and News Facilities to discuss medical news releases on a high level with high level officials of the national news services; and

WHEREAS, Collaboration on the truth and validity of the news releases and their impact on the lay public can only be assessed after investigation of the subject matter involved, therefore,

BE IT RESOLVED, That the appropriate agency or agencies of the American Medical Association request the national wire services not to publish such material until the American Medical Association has had this material investigated by the local medical society to determine the circumstances or the truth of the proposed release, and then if the matter is reported in its true light, the medical profession has no complaint with the subject matter regardless of what its results might be.

## Wording of Statement on Free Choice

(By the Delegates from the Academy of Medicine of Cincinnati and Hamilton County)

WHEREAS, The American Medical Association does not qualify nor describe the meaning of the term "free choice of physician"; and

WHEREAS, The Ohio State Medical Association's statement on third party plans uses the term "reasonable degree of free choice," therefore,

BE IT RESOLVED, That the words "a reasonable degree of" be deleted from such statement so that it will read "when free choice of physician", etc., to con-

form with use of the term by the American Medical Association.

## Mandatory Regulation That a Doctor of Medicine Be Present at All Ohio High School Athletic Body-Contact Contests

(By the Delegates from the Academy of Medicine of Cincinnati and Hamilton County)

WHEREAS, The Ohio State Medical Association and its component medical societies and their committees have successfully sponsored athletic injury and advisory conferences for the benefit of the high school athlete, his team physician where such exists, his coach, trainer, school officials, and, indirectly, his family; and

WHEREAS, The success of these conferences and the good accrued from them is most excellent, it is evident that more can be done for the high school athlete if the present practice of some of the high schools to have an official team physician present at all athletic body-contact contests, be extended to include all official body-contact contests in all public and private high schools in the State of Ohio; and

WHEREAS, No uniform code delineating the authority and relationship between any physician acting as a team physician and the high school officials and coaches exists in the State of Ohio as a whole, therefore,

BE IT RESOLVED, That the Ohio State Medical Association House of Delegates instruct the Council of the Ohio State Medical Association and it, in turn, instruct its proper committees to

(a) Continue the aforementioned athletic injury conferences at reasonable intervals and at geographic locations where the greatest number of high school athletes can receive the greatest amount of benefit; and

(b) Instruct the chairman of these committees to implement via the Athletic Control Boards of the Ohio State High School Athletic Association, the Ohio State High School Athletic Coaches Association, and all other proper organizations and authorities, a program which will result in agreement between these proper authorities and all high school officials in the State of Ohio that no official body-contact athletic contest will be played without a doctor of medicine present on the field from the beginning to the end of such contest; further

BE IT RESOLVED, That these committees of the Ohio State Medical Association write and implement a code of relationship between the doctor of medicine who will be the team doctor and the school officials which will establish, without doubt, the authority and the position of the team physician in all matters medical and surgical pertaining to any high school athlete before, during, and after such contests.

## Amendment to the Amended Immunization Act

(By the Delegates from the Academy of Medicine of Cincinnati and Hamilton County)

WHEREAS, The Ohio State Medical Association introduced a Bill to Amend Section 3313.671 of the Revised Code relative to immunization of school chldren; and

WHEREAS, This proposed amendment passed the House and Senate of the Ohio Assembly, therefore

BE IT RESOLVED, That the following bill be reintroduced at the next session of the Ohio State Legislature:

AN ACT

To amend section 3313.671 of the Revised Code relative to immunization of school children.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 3313.671 of the Revised Code be amended to read as follows:

Sec. 3313.671. (A) No pupil shall be admitted, at the time of his initial entry of each school year, to an elementary or high school for which the state board of education prescribes minimum standards in accordance with the provisions of division (D) of section 3301.07 of the Revised Code, unless such pupil has presented written evidence, . . . on a form prescribed by the director of health, that he has received, or is in the process of receiving, immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus by such means of immunization as may be approved by the department of health pusuant to the powers granted by section 3701.13 of the Revised Code, or unless such pupil has presented a written statement of his parent or guardian objecting to the immunization of such pupil against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus, or a statement substantiated by his physician, that such immunization is contraindicated medically. The provisions of this section shall not limit or impair the right of a board of education of a city, exempted village, or local school district to make and enforce rules or regulations to secure vaccination or immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus of the pupils under its jurisdiction . . . , provided that no child shall be required to submit to vaccination or immunization against poliomyelitis, smallpox, diphtheria, pertussis, or tetanus whose parent or guardian files a statement certifying that he is a bona fide adherent of a belief which does not accept vaccination or immunization as a means of preventing the contracting of or the spread of a communicable disease.

(B) Boards of health, legislative authorities of municipal corporations, and boards of township trustees on application of the board of education of the district or proper authority of any school affected by this section, at the public expense, without delay, shall provide the means of immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus to such pupils . . . whose parents or guardians state that they cannot afford to provide such immunizations.

Section 2. That existing section 3313.671 of the Revised Code is hereby repealed.

BE IT RESOLVED, That the legislative representatives be authorized to amend said proposed amendment to conform with the original proposed bill, if in their judgment such proposed bill can be passed at the next General Assembly of the State of Ohio.

## Ohio Medical Indemnity

(By the Delegates from Hamilton County)

WHEREAS, Blue Shield has been identified as the "Doctors' Plan," and

WHEREAS, Blue Shield Plans offered through the facilities of the Ohio Medical Indemnity, Inc. are intended and planned for the benefit of patients, and

WHEREAS, Ohio Medical Indemnity, Inc. has been unable to retain contracts under certain competitive conditions, therefore

BE IT RESOLVED, That officials of Ohio Medical Indemnity, Inc. be authorized to offer patients such plans that are competitive with other insurance or health payment plans.

## Proposed Increase in Annual Dues

(To be presented on behalf of The Council)

BE IT RESOLVED, That the per capita annual dues of the Ohio State Medical Association shall be increased from $30.00 to $35.00, effective January 1, 1963.

**(Refer to March, 1962, issue of *The Journal* for detailed statement by The Council enumerating Council's reasons for recommending the $5.00 increase in dues.)**

## Uniform Physical Examination Form

(To be presented by the Delegates from Mahoning County)

WHEREAS, For the past several years colleges and universities, both private and public, require applicants for admission to submit the results of physical examinations and history of past illnesses, injuries, operations and immuniza-

tions before admission to the college or university and even in some cases before considering the application for admission to the college or university, and,

WHEREAS, Each college and university has its own particular form to be completed, and

WHEREAS, Some applicants apply to several schools and bring to the examining physician two, three and even sometimes four separate blanks for completion, no two of which are alike, thus causing confusion in filling out the various forms and,

WHEREAS, If the several colleges and universities could agree on an entrance physical examination form similar to the scholastic college entrance board examinations it would greatly facilitate the procedure, both for the examining physician and the student applicants, therefore

BE IT RESOLVED, That the Mahoning County Medical Society go on record as urging the Ohio State Medical Association and the American Medical Association to facilitate and expedite the adoption of a uniform history and physical examination form by the several colleges and universities presently subscribing to the board of college entrance examiners and all other colleges and universities that can be contacted.

## Tax Deduction of Health Insurance Premiums

(By the Delegate from Huron County)

WHEREAS, The basic concepts of free Americanism are at stake, and

WHEREAS, The free practice of medicine is in extreme jeopardy, and

WHEREAS, The Ohio State Legislature has failed to implement the Kerr-Mills bill for Ohio, and

WHEREAS, Most physicians feel that H. R. 4222 offers no good solution for the medical care of the medically indigent either over or under 65 years of age, and

WHEREAS, The American Medical Association has failed to offer a good positive solution for the problem of the medical care of the medically indigent, thereby giving the defenders of free medicine only a negative approach, and

WHEREAS, The federal government has brought about this problem primarily by its high taxation and encouragement of the population to rely upon the federal government for all things, therefore

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association go on record as supporting a program which would give tax relief and permit deductions of premiums of voluntary medical insurance for all ages. Furthermore, be it resolved that those aged people not having suitable income to enable them to pay their voluntary medical insurance premiums have certificates offered to be accepted by insurance companies as payment of such premiums, and further,

BE IT RESOLVED, That the Ohio State Medical Association House of Delegates instruct the delegates of the American Medical Association of this approach and advise them to work for its acceptance and promotion by the American Medical Association.

## Political Action by the Medical Profession

(By the Delegate from Van Wert County)

WHEREAS, Organized Medicine and in particular its individual practitioners have traditionally stood on the side of good government, *for* the rights of the individual and his state and local governments, *for* the free and individual private enterprise system of the practice of Medicine and all other forms of business, and

WHEREAS, The events and pressures of the present and the immediate past 20 years have seemingly forced organized Medicine into an increasingly defensive and negative posture in the eyes of the press and the public as a whole, and

WHEREAS, Though by organized political action, with all the time and money implied in the term, we have won many battles only to have the specter of the welfare state rise again and again in new and ever more devious ways which demands ever increasing efforts of time and money to fight, and

WHEREAS, This continuous cycle of effort, though undeniably necessary has taken its toll of enthusiasm from those engaged in the fight, and, concomitantly, has isolated organized Medicine, in the eyes of the public and the press, more and more, and thereby placed us farther apart from the public, whom we serve and whose health is our concern by oath, and in whose behalf we are actually engaged in the battle to preserve our system of practice, and

WHEREAS, We ourselves have not been aware, or have not sufficiently expressed our awareness of our problem in relationship with the whole problem of good government and stable economy, and

WHEREAS, Our most effective spokesmen today speak individually and from the inherently more easily accepted viewpoint of private citizens exercising their right of free speech, uninfluenced by the "party line" of any Medical organization, e. g. Dr. Edward Annis, and

WHEREAS, In the current battle to defeat the King-Anderson Bill, existing organizations with positions of prestige and country-wide respect, enjoying a "favorable press," composed of representatives of *every* facet of community, business, and professional life, are battling more effectively than we, the best example of which is the Chamber of Commerce of the United States and its component state and local subsidiaries, and

WHEREAS, One can imagine a much more favorable public relations position and press, and perhaps more positive and permanent results, were we fighting not as a "vested interest" group but rather from within the combined ranks of a group composed of insurance people, Ministers, bankers, attorneys, industrial people, utility people, merchants, *etc.* and physicians, all with the common interest of furthering the cause of good government, which term includes our own just and good cause; therefore

BE IT RESOLVED, That the foregoing truths be incorporated in a review of official policy by the Council of OSMA concerning our engagement in political action as an organization, and that Council consider carefully the pros and cons of the following propositions:

(1) That organized Medicine, as such, withdraw in due course from identification with the field of political action;

(2) That our members be urged by official policy to turn their talents, time, and some of their money to individual support of the Chamber of Commerce of the United States and its subsidiaries and other like organizations, working zealously for the same objectives that Medicine has always believed in;

(3) That organized Medicine maintain an efficient information service on economic and legislative matters for its members, but that political action be carried on only by *individuals* in the roles of enlightened and free citizens, and as members and officers of organizations such as the Chamber of Commerce of the United States and its subsidiaries, which include *all* occupational groups which have common views toward the maintenance of a stable economy and good government, and further

BE IT RESOLVED That if, after due deliberation, this departure from our current thinking be deemed by Council to have real merit, Council be empowered to use this resolution as an embarkation vehicle, to be modified, added to or substituted, according to the wisdom of Council, for the introduction of this idea at the National level.

## Specialization and General Practice

(By the Delegate from Madison County)

WHEREAS, Population growth in Ohio's suburban and rural areas continues to parallel urban growth, and,

WHEREAS, The per capita number of M. D.'s in the non-urban areas is decreasing as the need for same increases, and,

WHEREAS, The various programs to interest M. D.'s to practice medicine in smaller communities has met with only modest success despite many incentives, and,

WHEREAS, The care of the general population in many

areas has become the province of cultist, faddist, and substandard practitioners while waiting voluntary development of interest by M. D.'s in these needy communities, and,

WHEREAS, Involuntary placement of practitioners some day soon will surely be the order of the day if socialistic trends continue to invade the field of medicine, therefore

BE IT RESOLVED, That no M. D. be allowed to practice as a Board Specialist in the State of Ohio without first having served three (3) years as a General Practitioner, or its equivalent (grandfather clauses and previous commitments excepted).

## Medical Care for Eye Patients

(By the Delegate from Defiance County)

WHEREAS, The report entitled, "Medical Care for Eye Patients," adopted by the American Medical Association House of Delegates in 1961, presents a comprehensive statement of a serious problem, and,

WHEREAS, The public interest requires that the potential dangers existing in the present situation be thoroughly understood by all physicians and its significance fully recognized by the public, and,

WHEREAS, No different principle applies to the care of the patient with ocular symptoms than to any other patient, now therefore,

BE IT RESOLVED, That the care of the eye, its associate structures and the related pathways of the brain which constitute the visual system, does not call for a *lesser* training than does the practice of medicine in general, and further,

BE IT RESOLVED, That the Ohio State Medical Association concurs in the position expressed in the American Medical Association report, "Medical Care for Eye Patients," and further,

BE IT RESOLVED, That this House directs the attention of all Ohio physicians to this report, and directs that the Society distribute a copy of this resolution and a copy of the report "Medical Care for Eye Patients" to all committees, councils and other bodies of the Society and to the component county societies for their guidance in all matters pertaining to the care of eye patients and to policy in relation to eye care, and further,

BE IT RESOLVED, That a copy of this resolution and a copy of "Medical Care for Eye Patients" be forwarded to the deans of all medical schools in Ohio and the chief of staff of all hospitals in Ohio.

## Nomination and Election of President-Elect

(By the Delegates from Summit County)

WHEREAS, It is the practice based on the constitution to both nominate and to elect the president of this association at the same meeting of the House of Delegates, and

WHEREAS, It is felt a constructive change would be made by nominating for the office of president-elect at one annual meeting and electing at the next annual meeting, therefore

BE IT RESOLVED, That an appropriate change be made in Article 7, Section 3 of the Constitution to effect this procedure, and further

BE IT RESOLVED, That this procedure be activated at the annual meeting of the House of Delegates in May, 1963 by nominating and electing a president-elect and also nominating at least two (2) candidates for the office to be filled by election at the annual meeting in May of 1964.

## Service-Type Insurance Plans

(By the Delegates from Summit County)

WHEREAS, The House of Delegates, Ohio State Medical Association, realizes that installing service-type insurance plans fundamentally changes the *economic* environment of practicing physicians in the short run, and

WHEREAS, Service-type insurance plans in some localities, by controlling a large *percentage* of a physician-member's income, usually come also to interfere with the *professional* environment of the physician and, in the long run, with how he practices medicine, and

WHEREAS, This House recognizes that relative-value fee schedules and "review committees" for full-payment programs that are based on full payment of "reasonable and ordinary charges" as well as plans setting forth specific fee schedules are *all* means to these same ends, therefore

BE IT RESOLVED, That this House of Delegates request Ohio Medical Indemnity to develop a *co-insurance* (85%-15%) contract to be offered as an alternative to its indemnity type policy, and further

BE IT RESOLVED, That this House reiterate its opposition to Ohio Medical Indemnity writing a service-type contract in fact or in effect — specifically, to writing a contract which *guarantees* full payment of physicians' fees.

## Ohio State Medical Association Staff

(By the Delegates from Summit County)

WHEREAS, It is the sincere opinion of this House that the knowledge and experience of Charles S. Nelson, Executive Secretary, Ohio State Medical Association, and his senior staff members could be well applied to innumerable county-level situations, and

WHEREAS, Conversely, this House feels a better understanding of county level needs and problems would make an even more effective state council and more functional state committees, therefore

BE IT RESOLVED, That the Council of the Ohio State Medical Association request of Mr. Nelson and receive from him by October, 1962 a plan for enlarging and developing a traveling field staff to operate under his supervision, and further

BE IT RESOLVED, That a minimum budget allocation of $30,000.00 for salaries for at least two (2) such properly qualified persons and an appropriate budget allocation for expenses be made by the proper committee and the Council for the fiscal year to begin January 1, 1963, and further,

BE IT RESOLVED, That Mr. Nelson's long range plan include assigning a staff aide for each Councilor District as funds become available.

## Medical Ethics

(By the Delegates from Summit County)

WHEREAS, Section 4, Chapter 4 of the By-Laws of Ohio State Medical Association has been interpreted to mean that any resolution dealing with the subject of professional relations with osteopaths is per se of ethical nature and thus must be referred to the Council of Ohio State Medical Association without discussion by this House of Delegates, and

WHEREAS, This House of Delegates feels the intent of this provision did not include taking from the purview of this House control of basic policy on the question of professional association with osteopaths, therefore

BE IT RESOLVED, That this question of interpretation be referred to a committee of this House for an opinion which this House may then ratify or reject.

## Professional Relations With Osteopathic Physicians

(By the Delegates from Summit County)

WHEREAS, In June, 1961 the American Medical Association House of Delegates saw fit to transfer the interpretation of the "Principles of Medical Ethics" insofar as they concerned professional association of physicians with doctors of osteopathy to the state association level, and

WHEREAS, The Council of the Ohio State Medical Association saw fit in December, 1961 to initiate change in the ethical framework for Ohio physicians by permitting, at the discretion of component county societies, professional association with osteopaths and, further, established criteria for adjudicating whether or not such associations were ethical, and

WHEREAS, This action will result in the need to admin-

ister a difficult, transitional situation at the county level, therefore,

BE IT RESOLVED, That this House of Delegates permit component societies to establish a membership classification for doctors of osteopathy at their discretion and with the approval of necessary constitutional changes by the Council of Ohio State Medical Association, and further

BE IT RESOLVED, That doctors of osteopathy not be granted membership in the Ohio State Medical Association at this time.

### Aid For The Aged

(By the Delegates from Montgomery County)

WHEREAS, It is becoming increasingly difficult to provide adequate and high quality medical services to patients under the Aid for the Aged program in Ohio; and

WHEREAS, A major cause of this difficulty is the unrealistic and low fee schedule established by Aid for the Aged; therefore

BE IT RESOLVED:

(1) That the Ohio State Medical Association take whatever steps that may be necessary to effect an upward revision of the Aid for the Aged fee schedule to a realistic level reflecting more closely today's cost of providing high quality medical service, and

(2) That, if necessary, efforts to secure this revision include full implementation of the Kerr-Mills law in Ohio.

### AMA Film Reviews

The American Medical Association's 16-year program of disseminating information on new medical motion pictures has reached a coveted milestone with the publication of the 1,000th film review in the *AMA Journal*. The AMA maintains a film library of 1,253 prints of 268 different subjects.

### Recent Opinions Rendered by The Attorney General

In an opinion rendered, Attorney General Mark McElroy ruled that under Ohio law a child may be placed for adoption without going through an authorized agency such as the county welfare department if the probate court authorized the placement prior to the time it was made.

Also, the probate court has the power to approve or disapprove a placement made illegally only after finding whether the placement is "for the best interest of the child."

Records of proposed placements are to be kept confidential by the probate court, and if the court asks a child welfare board to make an investigation of the proposed placement, the board has a duty to carry out the court's request.

* * *

In an opinion of the Attorney General, the Ohio Department of Health, various general and city health agencies do not have to be licensed under provisions of H. B. 416 pertaining to terminal distributors of dangerous drugs.

* * *

In another opinion, the attorney general said that dependents of servicemen currently in active duty are, if otherwise qualified, eligible to receive benefits under the Ohio Soldier's Relief Act.

## Art Exhibit Planned for OSMA Annual Meeting in Columbus

A Physicians Art Exhibit will be a feature of the OSMA Annual Meeting in Columbus, May 14 - 18, and applications for space will be reviewed by a committee headed by Dr. Thomas E. Newell, Dayton. Physicians who have paintings or other pieces of art are invited to fill out the following application form and mail it to The Ohio State Medical Association, 79 E. State St., Columbus 15, Ohio:

**Application for Space in Physicians Art Exhibit**

Name:.....Address:.....

City:.....

Type and number of pieces to be displayed: Painting.....Photography.....

Sculpture.....Crafts:.....other.....

Estimated amount of space required in lineal feet or square feet:.....

.....

General information, if any:.....

.....

.....

# AMA Loan Program . . .

## New Source of Financial Assistance to Medical Students. Interns, Residents. Made Available

A NEW SOURCE of financial assistance to medical students and to physicians in residency and internship training throughout the country will be opened up soon through a loan program underwritten by the American Medical Association.

The loan plan, which will be a function of the AMA Education and Research Foundation, will assist students at any stage of their medical education.

Financing of the program has been negotiated by the AMA with Continental Illinois National Bank and Trust Company, Chicago. Similar financing arrangements will be negotiated with other large banks as the program progresses.

### Those Eligible

Loans, which will be guaranteed against default by the AMA Education and Research Foundation, will be available to full-time students in good academic standing who are United States citizens, providing they attend a medical school approved by the AMA's Council on Medical Education and Hospitals or are in residency or internship training in a hospital approved by the Council.

### Guarantee Fund To Be Raised

The Foundation will be responsible for raising sufficient capital for the guarantee fund to meet all demands for loans and will provide certain necessary administrative facilities. Guarantee funds will be solicited from physicians and other private sources. Merck Sharp & Dohme, pharmaceutical manufacturing company, has agreed to match the first $100,000 contributed by physicians.

### Cost of a Loan

The cost of a loan at present during the educational period will be 5½ per cent simple interest. No payments of principal or interest will be required during the educational or training period. No charge will be made by the bank for carrying the interest that accumulates, an agreement which will result in considerable saving to the borrower. Notes will fall due five months after completion of the training period. Thus, the maximum duration will be seven years and five months — from the first year in medical school through residency. The five month grace period is intended to provide the physician time to locate after completing residency.

### Limit on Amount

Borrowers will be limited to $1,500 plus interest in any single 12-month period and $10,000 total in a seven-year period. Borrowers may not be indebted for more than $15,000 from all sources.

A new note, known as an "interim note," will be executed each time a student borrows additional funds. Five months after completion of training, the borrower may pay off the final interim note or convert it into a pay-out note which will bear interest at a rate agreed upon at the time the first loan was made. Currently, this interest will not exceed 3½ per cent at an add-on rate.

### About Repayments

If the loan to be repaid is less than $7,200, the borrower may choose a level payment of $30 or more a month. For larger loans, a level payment schedule may be chosen, or a 10-year payment schedule selected, with smaller payments initially and progressively larger payments later in the pay-out period.

The borrower will have the privilege of prepaying the loan and thus reducing interest costs. He may also choose to transfer his loan from the Continental Bank to a local bank in the community where he establishes his practice.

AMA - ERF officials said the program will require a guarantee fund equal to at least 8 per cent of total loans outstanding. In other words, for each $12,500,000 of loans, $1,000,000 must be maintained in the guarantee fund. When loan repayments begin, funds will be released to guarantee additional loans, and the program, therefore, eventually will become self-supporting.

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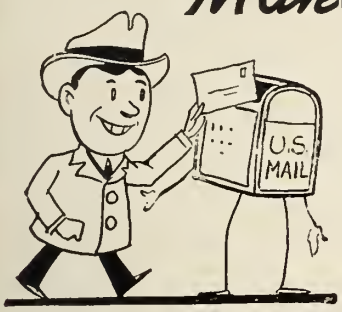
## Ohio Physicians Appointed to National Committees

Two members of the Ohio State University medical faculty have been appointed to important national advisory councils.

Dr. Samuel Saslaw, professor of medicine, has been appointed chairman of the newly created Allergy and Infectious Diseases Program-Project Committee of the National Institutes of Health.

Dr. Robert L. Wall, associate professor of medicine, has been appointed to the Subcommittee of Plasma of the National Research Council. The subcommittee serves as a professional advisory body to the American Red Cross and the Department of Defense.

# *Make Hotel Reservations Now!*




for the

## 1962 ANNUAL MEETING OF THE OHIO STATE MEDICAL ASSOCIATION

## May 14, 15, 16, 17, and 18

## COLUMBUS

*Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing*

| NAME AND LOCATION | SINGLE | DOUBLE | TWIN |
|---|---|---|---|
| NEIL HOUSE, 41 S. High St. (Headquarters Hotel) | $ 7.00- 9.50 | $ 9.50-12.00 | $12.00-15.00 |
| DESHLER HILTON HOTEL, W. Broad & N. High | $ 7.50-14.00 | $12.00-15.00 | $13.50-20.00 |
| PICK-FORT HAYES HOTEL, 31 W. Spring St. | $ 8.00- 9.50 | $11.00-12.00 | $14.00 up |
| HOTEL SOUTHERN, S. High & E. Main Sts. | $ 7.50- 8.00 | $10.00-10.50 | $11.00-12.50 |

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

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HOTEL RESERVATION BLANK
Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14-18, 1962, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Other

Arriving May.....at.....A. M.....P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

# "When You Begin Practice"

## Rural Health Committee Program for Future Physicians Draws Record Attendance at Ohio State and Cincinnati



*Dr. Petznick*

THE Committee on Rural Health was greeted by record attendances at both OSU and Cincinnati in presenting its 1962 Annual OSMA Special Talks for Medical Students. The program consisted of an afternoon of practical pointers on the economic and family aspects of setting up practice, followed by a complimentary evening dinner. Some 216 students, wives and girl friends heard the program at the Ohio Union for Ohio State University College of Medicine seniors on January 20. At the Cincinnati Academy of Medicine Building the program for University of Cincinnati College of Medicine juniors February 11 drew 115 guests.

The dinners were followed by three informal talks. OSMA President George W. Petznick, M. D., Shaker Heights, spoke on "The Physician and His Medical Society." Mrs. Victor R. Frederick, Urbana, a past-president of the Woman's Auxiliary, spoke on "The Physician's Wife." Robert E. Reiheld, M. D., Orrville, Rural Health Committee Chairman, spoke on "The Physician and His Community."

A fourth speaker at the Ohio State dinner was Dr. Richard L. Meiling, dean of the College of Medicine and an OSMA past-president. First District Councilor Charles W. Hoyt, M. D., Cincinnati, presided at Cincinnati. Tenth District Councilor Robert M. Inglis, M. D., Columbus, presided at Ohio State.

### Afternoon Speakers

Afternoon speakers at Cincinnati and Columbus included Dr. J. Martin Byers, Greenfield, who spoke on "Meeting Medical Emergencies"; Dr. Victor R. Frederick, Urbana, who spoke on "Selecting a Place to Practice," and Dr. Jasper M. Hedges, Circleville, who spoke on "Government Medical Programs Encountered In Practice." All three are members of the sponsoring committee.

Speaking on "Economics of Medical Practice" at Cincinnati was Dr. George N. Spears, Ironton, a former member of the committee, while Dr. Charles H. McMullen, Loudonville, chairman of the Committee on School Health, spoke at Ohio State.

One of the features of the program was the presentation of a stipend on behalf of OSMA to assist the campus Student AMA chapter presidents in attending the national Student AMA Annual Meeting. OSU Chapter President Ronald A. Naille and U. of C. Chapter President Walter Herzog were presented the stipends by Dr. Petznick at the dinner meeting.

The future physicians were told:

By Dr. Petznick: What does AMA stand for? The American Medical Association is a nonprofit, public service institution organized to protect the public health and to promote the highest quality of medical care for the American people. It is a professional organization existing to serve both the medical doctor and the public. Its objectives are to promote

*(Text Continued on Page 468)*

*Dr. Byers*



*Dr. McMullen*



*Dr. Spears*





*Dr. Hoyt*



*Dr. Hedges*



*Dr. Frederick*

*Shown at the "When You Begin Practice" special talks for medical students at Ohio State University January 20 and the University of Cincinnati February 11 are (reading clockwise):*

DR. GEORGE W. PETZNICK, *Cleveland, OSMA President;* DR. CHARLES W. HOYT, *Cincinnati, First District Councilor;* DR. JASPER M. HEDGES, *Circleville, member, Committee on Rural Health;* DR. VICTOR R. FREDERICK, *member, Committee on Rural Health;* DR. ROBERT M. INGLIS, *Columbus, Tenth District Councilor; Some 115 University of Cincinnati medical students, their guests, and speakers at the complimentary dinner tendered them by OSMA;* DR. PETZNICK *presenting a stipend to Cincinnati SAMA Chapter* PRESIDENT WALTER HERZOG; DR. GEORGE N. SPEARS, *Ironton, former member, Committee on Rural Health;* DR. CHARLES H. MCMULLEN, *Loudonville, Chairman, Committee on School Health, and* DR. J. MARTIN BYERS, *Greenfield, member, Committee on Rural Health.*



*Dr. Inglis*







*(Text Continued from Page 466)*

the science and art of medicine and the betterment of public health.

By Dr. Reiheld: The physician, because of his educational background, his ability and his professional responsibilities, is expected to accept a role of leadership in affairs of his community.

By Mrs. Frederick: Whether she realizes it or not, the physician's wife is his personal public relations representative.

By Dr. Frederick: The physician who selects carefully the community in which he wants to live will find the practice of medicine an enjoyable, rewarding and interesting one.

By Dr. Byers: The physician cannot wait for a medical emergency to present itself before he starts preparing himself to meet medical emergencies.

By Dr. McMullen: One of the main keys to a successful practice is efficient office and medical record arrangements and allocation of appointments so that adequate time can be provided for each patient.

By Dr. Hedges: The many medical programs operated by various local, state and Federal agencies all have different systems, different requirements, different policies, and different forms. The young physician who acquaints himself with these will avoid considerable waste of time and effort.

By Dr. Spears: The physician just starting practice will find that adequate time, and not fees, should be his major concern. He should learn to arrange his time efficiently, for in doing so he will find he has time to practice good medicine. Time is the most valuable possession of a good physician.



*Scenes of the program for medical students (reading clockwise): Shown enjoying the complimentary dinner at Ohio State are some of the nearly 220 students and their wives, speakers and special guests. OSMA* PRESIDENT PETZNICK *presents a stipend to OSU Student AMA Chapter* PRESIDENT RONALD A. NAILLE. DR. ROBERT E. REIHELD, *Orrville, Chairman, Committee on Rural Health.* DR. RICHARD L. MEILING, *Columbus, Dean, OSU College of Medicine.* MRS. VICTOR R. FREDERICK, *Urbana, a past-president of the Woman's Auxiliary.*

*Mrs. Frederick* *Dr. Meiling* *Dr. Reiheld.*







# Licenses Issued . . .

## Following December Examinations, State Medical Board Issues Ohio Certificates to Fifty-Five Doctors of Medicine

EXAMINATIONS conducted by the State Medical Board of Ohio on December 18-20, 1961 were considered by the Board on January 30, and results announced by Dr. H. M. Platter, secretary.

Fifty-five graduates of schools of medicine were authorized to receive certificates to practice medicine and surgery in Ohio, and 27 graduates of osteopathic schools were authorized to receive certificates to practice osteopathic medicine and surgery.

In the limited branches, certificates were awarded to 6 mechanotherapists, 11 chiropractors, 7 masseurs, 5 cosmetic therapists and 5 physical therapists.

Highest grade in the examinations for doctors of medicine was made by Mervyn M. Sopher, Cleveland, a graduate of the University of Calcutta, India, with an average of 90.9.

Second highest grade was made by Martin J. Fischer, Akron, a graduate of Washington University, with 90.7, and third high was Richard C. Wamsley, Cleveland, a graduate of Jefferson Medical College, with a grade of 90.

The following persons were authorized to receive licenses to practice medicine and surgery (home town is indicated in parenthesis when it is different from address given at time of examination):

### Graduates of U. S. and Canadian Schools

James F. Barnhill, Cincinnati (Dayton), Northwestern University; Gerald T. Bowen, Detroit, Mich. (Cheboygan, Mich.), George Washington University; Glenn O. Bratcher, Cincinnati, Marquette University; William A. Browne, Kettering (Greenville), Jefferson Medical College; Victor P. Conforti, Terre Haute, Ind., Duke University; John E. Dymond, Wyandotte, Mich. (Decatur, Ill.), University of Illinois;

Martin J. Fischer, Columbus (Akron), Washington University; William C. Fritsch, Cleveland (Chicago), University of Chicago; David J. Graubard, Shaker Heights (Philadelphia, Pa.), Jefferson Medical College; Ronald G. Hines, Canton (Victoria, B. C., Canada), University of Toronto, Canada; Mary Evellyn H. Houck, Toledo (Flint, Mich.) University of Michigan; Paul F. Keith, Westfield, N. J.; New York Medical College;

Alvonso Perisi, Cleveland, University of Ottawa, Canada; Albert Puskas, Columbus (Vancouver, B. C., Canada), University of British Columbia; Edward L. Reilly, Columbus, Seton Hall College of Medicine, Jersey City, N. J.; Daniel C. Shannon, Cincinnati, Stritch School of Medicine, Loyola University; Sheldon Sidell, Parma (Seattle, Wash.), University of Washington; James B. Stanton, Gallipolis, University of Western Ontario; Richard C. Wamsley, Cleveland, Jefferson College.

### Graduates of Foreign Schools

Raul D. Alfano, Cincinnati (Lima, Peru), University of San Marcos, Lima, Peru; Humberto C. Bautista, Columbus, National Aut. University of Mexico; Hans G. Bergeest, Oxford, University of Marburg, Germany; Otto N. Bernath, Barberton, University of Budapest, Hungary; Rulolf F. Binder, Chardon, University of Vienna, Austria; Charles J. Burns, Washington, D. C. (Lima), Royal College of Surgeons & Physicians, Dublin, Ireland;

Arturo Castillo, Toledo, National Aut. University of Mexico; Luciano Celori, Marquette, Mich., University of Rome, Italy; Vacys Dragunas, Manteno, Ill., University of Frankfurt/Main, Germany; Mariano L. Galainena, Cleveland (Havana, Cuba), University of Havana; Gaspare Galati, Cleveland, University of Rome, Italy; Arthur Gelbart, Willoughby, University of Munich, Germany; Sigismund L. Harder, Cleveland, University of Goettingen, Germany; Feife F. Hofman, Cleveland, University of Leiden, the Netherlands; Marcel Hundziak, Columbus, University of Frankfurt/Main, Germany;

Lilia F. Ibabao, Cleveland, Manila Central University, Philippines; Demetrius Jarosewycz, Alton, Ill., University of Lwow, Poland; Nina Kateryniuk, Louisville, Ky., University of Graz, Austria; Mearl M. Keithahn, Chicago (Fairmont, Minn.), University of Madras, India; Konrad J. Lasek, Baltimore, Md., University of Zurich, Switzerland;

Nicolo Mileti, Dayton, University of Polermo, Italy; Halina Minkevich, Cincinnati, University of Wilno, Poland; Kurt M. Morbitzer, Ancora, N. J., University of Erlangen, Germany; Philip F. Mussari, Chicago, University of Naples, Italy; Carl J. Ponischil, Cleveland, University of Wuerzburg, Germany; Branko Radich, Norwich, Conn., University of Bologna, Italy;

Natalie Serow, Gibson City, Ill., University of Munich, Germany; George Slonicki, New York City, Medical Institute of Kiev., Russia; Mervyn M. Sopher,

Cleveland, University of Calcutta, India; Karamfil S. Staneff, Columbus, University of Heidelberg, Germany; Peter Stungys, Cleveland, University of Vytautas the Great, Lithuania;

Benjamin C. Tancinco, Toledo (Philippines), University of Philippines; Nicholas Timchinov, Cleveland, Odessa Medical Institute, Russia; Joe J. Trevino, Columbus (Raymondville, Texas) National Aut. University of Mexico; Paul D. Valvo, Mt. Freedom, N. J., University of Messina, Italy; Frank Zalasdy, West Brentwood, L. I., N. Y., University of Budapest, Hungary.

* * *

## Licensed To Practice in Ohio Through Endorsement

The following physicians recently were licensed to practice by the State Medical Board through endorsement of their licenses to practice in other states or their certification by the National Board of Medical Examiners:

Julio B. Acosta, Cleveland, St. Marcos University, Lima, Peru; Felix Andracovich, Columbus, University of Buenos Aires, Argentina; Donald Martin Bebak, Youngstown, State University of New York; Hugh deEvereaux Bennett, Cleveland, University of Chicago; Paula Helene Bocsor, Lakewood, University of Budapest;

Peter H. Cahn, Columbus, Indiana University; Joseph Carlucci, Cleveland, University of Bologna, Italy; James Richard Carroll, Columbus, University of Alberta, Canada; Lawrence Martin Clark, Akron, Temple University; Richard Bryon Corradi, Cleveland, University of Rochester; Boghos H. Cutujian, Cleveland, American University of Beirut, Lebanon;

John Joseph Dettling, Akron, Georgetown University; Wilma Anita McVey Evans, Cleveland, Albany Medical College; Richard Bahr Fleming, Cincinnati, University of Cincinnati; Fedro F. Garcia, Columbus, University of Havana; Felix Garfunkel, Cincinnati, Central University of Ecuador; Ali Gharib, Cleveland, University of Teheran, Iran; Peter Holford Gwynne, Columbus, University College Hospital, London;

Allan Augustus Hoffman, Jr., Cleveland, Harvard Medical School; George Clerihew Hoffman, Cleveland, Cambridge University, London; Herbert Charles Khalouf, Cleveland, University of Pittsburgh; Shirley Ann Thompson Khalouf, Cleveland, Woman's Medical College of Pennsylvania; Gustav Kolodziejczak, Columbus, Medical Academy of Danzig, Poland; Zbigniew M. Kuberczyk, Youngstown, French University of Beirut, Lebanon;

Norman Wilbur Lavy, Cleveland Heights, University of Maryland; Demetrios Geo. Liapopoulos, University of Athens, Greece; K. John Lieu, Columbus, St. John's University, Shanghai, China; Francis Lawrence McCafferty, Cleveland, St. Louis University; John Glass McCohahy III, Harvard Medical School; David Meckler, Canton, Jefferson Medical School; Gary E. Miller, Cleveland, University of Texas; Raul E. Montero, Cleveland, National University of Mexico;

Jane Carol Schutter Perrin, Cincinnati, Harvard Medical School; Sophie Perry, Springfield, University of Athens, Greece; William Alfred Powell, Millersburg, George Washington University; Lindsay Lee Pratt, Cleveland, Jefferson Medical College; Warden Miller Rimel, Cincinnati, State University of Iowa; Nicholas Samuel Russinovich, Cleveland, University of Zagreb, Yugoslavia;

Khamis I. Saba, Cincinnati, American University of Beirut. Lebanon; Ronald J. A. Schoeck, Cleveland, St. Louis University; Kurt J. Schulz, Massillon, University of Hamburg; Berkeley Slutzker, Dayton, University of Illinois; Mario Stefanini, Toledo, University of Rome, Italy; Duane Leo James Stemle, Cleveland, Indiana University; Valeriano Suarez, University of Havana;

Mario Tami, University of Genoa, Italy; Reinhard Westphal, Columbus, University of Freiburg; William James Williams, Tallmadge, Hahnemann Medical College.

### Additional Physicians Licensed

Following is an additional list of physicians licensed by the State Medical Board through endorsement of their licenses to practice in other states or certification by the National Board of Medical Examiners:

Jeffrey H. Apton, University of Lausanne, Switzerland; Marciano F. Aquino, Cleveland, University of Santo Tomas, P. I.; Harry Y. Azadian, Columbus, Harvard Medical College;

Robert Lee Barenberg, Cleveland, Albany Medical College; Darius Behnam, University of Paris, France; Harry Bjornstad, Canton, University of Copenhagen, Denmark; William Dean Bolander, Worthington, College of Medical Evangelists; Robert Ernest Botti, Cleveland Heights, University of Pennsylvania; Arthur Dean Boyd, Cincinnati, University of Pittsburgh; Carmel Joseph Bozzi, Chillicothe, Hahnemann Medical College;

Norman Andrew Clemens, Cleveland Heights, Harvard Medical School; Joseph Cohen, Cleveland, University of Cairo, Egypt; William S. Conway, Sandusky, University of Maryland; Csaba Ferenc Csetri, Columbus, University of Szeged, Hungary;

Harley R. Deere, Jr., Columbus, Baylor University; William Victor Delaney, Jr., Columbus, State University of New York; Arthur M. Dell, University of Havana; Robert T. P. deTreville, Cincinnati, Medical College of South Carolina; George H. Dietz, Youngstown, State University of New York;

Arnold Marvin Epstein, Columbus, University of Virginia; Arthur Fishman, Columbus, Temple University; Edward L. Gould, Columbus, Tufts University; George Nolan Grant, Columbus, University of Oklahoma; Natale Graziano, University of Genoa, Italy;

Richard W. Hogman, Cleveland Heights, University of Michigan; Simon Horenstein, Shaker Heights,

University of Illinois; James Aubrey Kemp, Gallipolis, Medical College of Georgia; Carl B. Klodell, Youngstown, University of Pittsburgh; Otto A. J. Kurz, University of Marburg; William Thomas Luckey, Columbus, Indiana University;

Niall P. MacAllister, Cleveland, Royal College of Surgeons, Dublin, Ireland; Manuel T. Martin, Cleveland, Manila Central University, P. I.; Louis Ralph Mengoli, Columbus, Johns Hopkins University; Rotruad (f) Moslener, Columbus, University of Goettingen; Tarik O. Muskara, Cleveland, University of Istanbul;

Simon Ohenessian, Chardon, Columbia University; Maurice Oudiz, Youngstown, University of Cairo, Egypt; Pietro Pedone, University of Pavia, Italy, Eugene Victor Perrin, Cincinnati, University of Michigan; John (Ivan) Podiuk, Niles, University of Graz; William E. Powell II, South Euclid, University of Rochester; Robert M. Rogers, Cleveland, University of Pennsylvania; Donald Max Roser, Cleveland, University of Washington;

Chester L. Samuelson, Findlay, State University of Iowa; Huseyin Sarikaya, Canton, University of Istanbul, Turkey; Helmut H. M. Schories, Columbus, University of Erlangen; Irving L. Schwartz, Cincinnati, New York University; John P. Sheils, Cleveland, Medical College of Virginia; George Seamon Shields, Cincinnati, Cornell University;

Frederick H. Shillito, Columbus, Harvard Medical School; William Davy Smith, Zanesville, University of Toronto; John Gilbert Stafne, Toledo, University of Minnesota; George Stefaniwsky, University of Prague; Melvin Jerald Sturman, Columbus, University of Washington;

Luigi Joseph Tornambe, Cleveland, University of Catania, Italy; William B. Triplett, Columbus, University of Louisville; Albert W. Van Sickle, Clermont County, University of Rochester; Aivests L. Vecozols, Columbus, University of Bonn;

George L. Wadsworth, Columbus, University of Oregon; Robert Joseph White, Cleveland, Harvard Medical School; James Joseph Whitford, Cleveland, Georgetown Medical School; Norman Samuel Williams, Marion, Tufts University; Linda Love Wood, Columbus, University of Colorado.

**By Examination** — dated December 19, 1961, Ernesto Garcia, Cleveland, University of Guadalajaro, Mexico.

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The University of Cincinnati's Institute of Industrial Health is offering graduate fellowships in industrial medicine. The institute, which is in the College of Medicine, provides professional training for graduates of approved medical schools who have completed at least one year of internship. Requests for additional information should be addressed to: Secretary, Institute of Industrial Health, College of Medicine, Eden and Bethesda Avenues, Cincinnati, 19, O.

## Legislative Conference April 13 by Ohio Woman's Auxiliary

A Legislative Conference, sponsored by the Woman's Auxiliary to the Ohio State Medical Association with the cooperation of the association, will be held at the Neil House, Columbus, on Friday, April 13, opening at 9:30 A. M. EST.

The president of each County Auxiliary has been invited to select members of the local auxiliary to attend. The goal is at least two representatives from each local auxiliary. State Auxiliary officials also will be expected to attend.

Following registration and a talk, "Why We're Here" by Mrs. Lester W. Sontag, Yellow Springs, president of the Auxiliary, Mrs. V. R. Frederick, Urbana, will speak on the subject, "H. R. 4222—Its Provisions and Why We Oppose It." Mrs. Frederick is area chairman, Committee on Legislation, Woman's Auxiliary to the American Medical Association and a former president of the Ohio Auxiliary.

Dr. George W. Petznick, Cleveland, president, Ohio State Medical Association, will speak on "H. R. 4222 Can Be Beaten. How?" Some of the constructive and positive activities and programs of the OSMA and the AMA will be discussed by Mr. Charles W. Edgar, administrative assistant, Ohio State Medical Association, in his talk, "Accentuating the Positive."

"Campaign Techniques" is the subject of a talk by Mrs. Lee Ann Elliott, Chicago, legislative department, American Medical Association.

After a question and answer period and a complimentary luncheon, there will be two talks by members of the administrative staff of the Ohio State Medical Association.

Mr. George H. Saville, director of public relations and assistant executive secretary, will address the conference on the subject, "Role of the Doctor and His Wife in Politics."

The subject, "How the Auxiliary Members Can Participate in the OSMA Legislative Program," will be presented by Mr. Hart F. Page, assistant director of public relations.

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### Gets 50-Year Award in Florida

Recently, friends of Dr. and Mrs. E. R. Shaffer, formerly of Akron, tendered them a dinner at Port Charlotte, Florida, their present home, honoring Dr. Shaffer who graduated from medical school 50 years ago. Presentation of the Ohio State Medical Association 50-year award was made by Dr. Fred P. Nisi, president of the Charlotte County Medical Society. Dr. Shaffer retired as health commissioner of Summit County in 1959.

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With 33.4 live births per 1000 population, Alaska was No. 1 in 1960. West Virginia was at the bottom of the state list with 21.2 per 1000.

# County Officers Conference . . .

## Key Persons from County Medical Societies Are Guests of The Association for Sunday Get-Together in Columbus

THE Annual Conference of County Medical Society Officers and Committeemen with members of the State Association Council was held in Columbus on Sunday, February 25, with 196 persons attending. Invited to this conference were key officers of County Medical Societies, chairmen of Legislative, Public Relations and Grievance Committees as well as members of speakers' bureaus on H. R. 4222. Among persons on the State level invited were members of the Legislative Committees, Judicial and Professional Relations Committee, Past-Presidents, and AMA Delegates and Alternates.

### Battle Lines Drawn

"Medicine's Battle of the Century," was the theme of the morning session dealing with the medical profession's part in opposition to H. R. 4222, the King-Anderson-Kennedy proposal to establish a system of compulsory health insurance within the Social Security program.

Dr. Ernest B. Howard, Assistant Executive Vice-President of the American Medical Association, led off the discussion with a "Report from Washington." Dr. Howard reviewed the present status of this proposed legislation and urged that every doctor take part in the campaign. The campaign at present revolves around five main efforts, he said: Individual and group work back home; liaison with church groups interested in this subject; promotion of voluntary health insurance; increased effort toward an educational relationship between doctor and patient; and association of every doctor with the American Medical Political Action Committee.

The executive director of the American Medical Political Action Committee, Joe D. Miller, was the next speaker, presenting the theme, "Organized Political Action." This new committee is governed by a board of directors appointed by the AMA Board of Trustees. It is not affiliated with any political party. Support is by individual membership of doctors and by donations. Literature accompanying a blank for response has been sent to every member of the AMA. Mr. Miller urged that every doctor in Ohio respond with membership and with a donation.

"How the Woman's Auxiliary Can Help" was explained by Mrs. Lester Sontag, Yellow Springs, President of the Woman's Auxiliary to the Ohio State Medical Association. Mrs. Sontag pointed out that the Auxiliary is well organized on national, state and county levels and is ready and able to help medical organization.

"What To Say and How To Say It" was the title of a talk by Robert A. Lang, executive secretary of the Academy of Medicine of Cleveland, and a man with considerable public speaking experience. Mr.




*These officers of OSMA presided at respective sessions during the day: left to right,* Dr. George W. Petznick, *Cleveland, OSMA President;* Dr. Edwin H. Artman, *Chillicothe, Immediate Past-President; and* Dr. Geo. J. Hamwi, *Columbus, President-Elect, standing beside the exhibit on literature.*

# Some of Those Who Attended Columbus Meeting



*This scene in the Ball Room of the Deshler Hilton Hotel shows part of the group of more than 190 persons who attended the conference from all parts of Ohio.*

Lang said that techniques of public speaking should always be secondary to a sincere and enthusiastic presentation, tailored to the particular audience. His talk centered around the theme of the doctor's responsibility to inform the public on matter of vital public interest in health, such as the proposed legislation to establish a system of compulsory health insurance within the Social Security program.

### Medicine in Action

Theme of the afternoon discussion was "Medicine in Action."

Dr. Frank F. A. Rawling, chairman of the OSMA Judicial and Professional Relations Committee, spoke on "Handling of Disciplinary and Grievance Problems." Dr. Rawling stressed the importance of the grievance committee . . . no matter what name it is given. Grievances are primarily local problems, he said, and should be dealt with on the local level except in unusual cases. When it becomes evident that disciplinary action should be taken against a member, this should be done only within provisions of the constitution and bylaws of the County Society and the State Association.

Dr. Edmond K. Yantes, Wilmington, chairman of the Executive Committee of Ohio Medical Indemnity, discussed the subject "O. M. I. — Its Problems and Plans." Dr. Yantes described the program of OMI since its creation by the Ohio State Medical Association, and the constant efforts to improve its services for the good of the public, within the limits of sound insurance principles.

"Need a Home Care Program in Your County?" This subject was discussed by Dr. P. J. Robechek, Cleveland, chairman of the OSMA Committee on Care of the Aged. Copies of a pamphlet covering the high points of this talk are available on request from the OSMA Headquarters office.

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, described the work of the Headquarters office of OSMA, under the title, "Your State Office — What It Can Do for You." He outlined services to individual members, to County Medical Societies, other organizations and the public. Highlights of these services are available on request from the Headquarters office.

### On the Local Front

Highlight of the program was a period devoted to Councilor District Conferences. During this period, officers and committeemen from each district met with respective District Councilors to discuss matters of common local interest.

Three additional conferences were held during this same period. Delegates to the American Medical Association met in one group. In another conference the OSMA Committee on State and Federal Legislation met with local committeemen. The Future Planning Committee of the State Association also met in separate conference.

An exhibit prepared by the OSMA Department of Public Relations portrayed the literature that is available pertaining to the King-Anderson Bill, H. R. 4222. More than 31,000 pieces of literature were ordered by those present. Physicians who plan talks before organizations or who wish to make literature available to their patients, pointing out the pitfalls of including compulsory health care for the aged under the Social Security program, are invited to write the Columbus office.

The program of the day was opened by Dr. George W. Petznick, Cleveland, President of the OSMA, with



*First District: Councilor Charles W. Hoyt, third from left, presiding.*



*Second District: Councilor Ray M. Turner, head of table, presiding.*



*Third District: Councilor Floyd M. Elliott, third from left, presiding.*



*Fourth District: Councilor E. R. Murbach, sixth from left, presiding.*



*Fifth District: Councilor Henry A. Crawford, center, presiding*

an explanation of "Why We Are Here." He explained that this traditional annual conference is designed to bring together officers of the OSMA with officers and key committeemen of County Medical Societies for an exchange of ideas on issues of current interest.

Dr. George J. Hamwi, Columbus, President-Elect of OSMA, presided at the afternoon session. Dr. Edwin H. Artman, Chillicothe, Immediate Past-President, presided at part of the afternoon session also.

During the noon hour a complimentary luncheon was served.

Following is a roster of those present:

### Roster of Those Present

OFFICERS AND COUNCILORS: George W. Petznick, Cleveland, President; Geo. J. Hamwi, Columbus, President-Elect; Edwin H. Artman, Chillicothe, Past-President; Philip B. Hardymon, Columbus, Treasurer; First District Councilor, Charles W. Hoyt, Cincinnati; Second District Councilor, Ray M. Turner, Springfield; Third District Councilor, Floyd M. Elliott, Ada; Fourth District Councilor, Edwin R. Murbach, Archbold; Fifth District Councilor, Henry A. Crawford, Cleveland; Sixth District Councilor, Robert E. Tschantz, Canton; Seventh District Councilor, Benjamin C. Diefenbach, Martins Ferry; Eighth District Councilor, Robert C. Beardsley, Zanesville; Tenth District Councilor, Robert M. Inglis, Columbus; Eleventh District Councilor, Lawrence C. Meredith, Elyria.

FIRST DISTRICT: **Adams County** — Hazel L. Sproull, Juan Young, West Union; **Butler County** — James L. Sawyer, Middletown; **Clermont County** — Phillips F. Greene, New Richmond; Carl A. Minning, Batavia; **Clinton County** — Edmond K. Yantes, Wilmington; **Hamilton County** — George D. J. Griffin and Mrs. Griffin, Robert Howard, Frank Mayfield, Mr. Edward F. Willenborg and Mr. W. Eugene Little, all of Cincinnati.

SECOND DISTRICT: **Champaign County** — Victor R. Frederick, Mrs. Victor R. Frederick, Myron J. Towle, all of Urbana; **Clark County** — W. H. Crays, Max D. Graves, D. Joseph Parson, John F. Riesser, and Mrs. Marion L. Wilcoxson, all of Springfield; Ernest Hoffman, Jr., Yellow Springs. **Darke County** — James H. Dickey, Charles E. Gariety, Maurice M. Kane, and Giles Wolverton, all of Grenville. **Greene County** — Alvin B. Salisbury, Jr., Fairborn, Roger C. Henderson, Robert D. Hendrickson, B. F. Lee, E. J. Schmitt, John L. Wolff, Mrs. C. K. Elliott, all of Xenia; Mrs. Lester Sontag, Yellow Springs; **Miami County** — Paul E. Foy, Troy; William W. Trostel, Piqua; George A. Wood-

house, Pleasant Hill; **Montgomery County** — Lynne E. Baker, Robert M. Craig, George H. Garrison, T. L. Light, W. A. Reiling, Mr. Robert F. Freeman and Mr. Kenneth C. Evans, all of Dayton; A. V. Black, Centerville; **Preble County** — Michael O. Phillips, Eaton.

THIRD DISTRICT: **Allen County** — Thomas D. Allison and David L. Steiner, both of Lima; **Auglaize County** — Robert S. Oyer, Robert S. Sobocinski, both of Wapakoneta; **Hancock County** — Benjamin H. Saunders, Jr., Donald R. Brumley, both of Findlay; **Hardin County** — Jack C. Lindsey, Kenton; **Marion County** — Frederick T. Merchant, Marion; **Van Wert County** — Edward E. White, Van Wert; **Wyandot County** — Richard L. Garster and Allen F. Murphy, Upper Sandusky.

FOURTH DISTRICT: **Defiance County** — William S. Busteed, Defiance; **Lucas County** — William A. Blank, James I. Collins, E. F. Glow, J. Howard Holmes, H. F. Howe, Frank F. A. Rawling, Robert P. Ulrich, and Mr. Robert W. Elwell, all of Toledo; **Ottawa County** — Patrick Hughes, F. Kraft Ritter, Port Clinton; **Wood County** — Paul F. Orr, Perrysburg.

FIFTH DISTRICT: **Ashtabula County** — William J. McCarthy, Ashtabula; **Cuyahoga County** — John H. Budd, Fred W. Dixon, William E. Forsythe, Charles L. Hudson, John D. Osmond, Jr., P. John Robechek, Mr. Robert A. Lang and Mr. Donald W. Mortimer, all of Cleveland; Howard P. Taylor, Shaker Heights; Eugene A. Ferreri, South Euclid. **Lake County** — Maxwell E. Burnham, Painesville; Harry A. Killian, Willoughby.

SIXTH DISTRICT: **Columbiana County** — Harlow F. Banfield, Jr., East Liverpool; Virgil C. Hart, Salem, Janis Lauva, Wellsville; Leonard S. Pritchard, Columbiana; **Mahoning County** — Harlan P. Mcgregor, North Lima; Asher Randell, Charles W. Stertzbach, Craig C. Wales, and Mr. Howard C. Rempes, all of Youngstown; **Portage County** — L. Fred Bissell, Aurora; Robert E. Glasgow, Ravenna; Robert E. Roy, Ravenna; **Stark County** — Graydon D. Underwood, Navarre; C. V. Smith and William A. White, Jr., Canton; **Summit County** — James G. Roberts and Mr. Sidney H. Mountcastle, Akron; **Trumbull County** — Thomas E. Wilson and Mrs. Edward Bauman, Warren.

SEVENTH DISTRICT: **Belmont County** — R. H. McCommon, Shadyside; James F. Sutherland, Martins Ferry; **Carroll County** — Thomas J. Atchison and Carl A. Lincke, Carrollton; **Coshocton County** — Gerald A. Foster, Coshocton; **Harrison**

*Eleventh District: Councilor Lawrence C. Meredith, left, standing, presiding.*

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*Sixth District: Councilor Robert E. Tschantz, extreme right, face partly hidden, presiding.*



*Seventh District: Councilor Benjamin C. Diefenbach, head of table, presiding.*



*Eighth District: Councilor Robert C. Beardsley, head of table, presiding.*



*Ninth District: Former Councilor Carter Pitcher, second from left, presiding in the absence of Councilor Chester H. Allen.*



*Tenth District: Councilor Robert M. Inglis, third from right, presiding.*





*"Medicine's Battle of the Century," was the theme of four talks dealing with opposition to H. R. 4222. Shown as they presented the four aspects of the subject are, left to right,* MRS. LESTER SONTAG, *President of the Woman's Auxiliary to OSMA;* DR. ERNEST B. HOWARD, *Chicago, Assistant Executive Vice-President of the AMA;* JOE D. MILLER, *Chicago, Executive Director of the American Medical Political Action Committee; and* ROBERT A. LANG, *Cleveland, Executive Secretary of the Academy of Medicine of Cleveland.*

**County** — George E. Henderson, New Athens; **Jefferson County** —Earl Rosenblum, Steubenville; **Tuscarawas County** — Jay W. Calhoon, Uhrichsville; Eugene R. Hammersley, Tuscarawas; Robert E. Rinderknecht, Dover.

EIGHTH DISTRICT: **Athens County** — Wolfhard Baumgaertel, Athens; **Fairfield County** — Stephen R. Hodsden, Baltimore; Jack Kraker, Lancaster; **Licking County** — Lawrence H. Miller, Granville; Warren N. Koontz and James A. Quinn, Jr., Newark; **Muskingum County** — Benjamin W. Gilliotte and Robert S. Martin, Zanesville; Rankin A. Nebinger, Roseville; George T. Thompson, Philo; **Perry County** — Olen D. Ball, New Lexington.

NINTH DISTRICT: **Gallia County** — Oscar W. Clarke, Gallipolis; **Lawrence County** — Ralph F. Massie and George Newton Spears, Ironton; **Pike County** — Albert Shrader and Kenneth Wilkinson, Waverly; **Scioto County** — William E. Daehler, Spencer W. Miller, Carter L. Pitcher, all of Portsmouth.

TENTH DISTRICT: **Fayette County** — Robert A. Heiny, Washington C. H.; **Franklin County** — Wade D. Bower, Harve M. Clodfelter, Thomas R. Curran, Richard L. Fulton, David H. Greegor, Thomas M. Hughes, Richard L. Meiling, C. C. Sherburne, Judson D. Wilson and Mr. W. Bill Webb, all of Columbus; **Knox County** — James C. McLarnan, Delbert C.



*"Medicine in Action" was the theme of the afternoon program. Participants in discussions were, left to right,* DR. P. J. ROBECHEK, *Cleveland, chairman of the OSMA Committee on Care of the Aged;* DR. EDMOND K. YANTES, *Wilmington, Chairman of the Executive Committee of Ohio Medical Indemnity;* MR. CHARLES S. NELSON, *Columbus, Executive Secretary of the State Association; and* DR. FRANK F. A. RAWLING, *Toledo, Chairman of the OSMA Judicial and Professional Relations Committee.*

Schmidt, Mt. Vernon; **Morrow County** — Joseph P. Ingmire, Mt. Gilead; **Pickaway County** — Francis W. Anderson, E. L. Montgomery, Robert Smith, Sr., all of Circleville; **Ross County** — James R. Manchester, David McKell, Robert E. Swank, all of Chillicothe.

ELEVENTH DISTRICT: **Ashland County** — Myrle D. Shilling and Paul J. Sauder, Ashland; **Holmes County** — Luther W. High, Owen F. Patterson, Neven P. Stauffer, all of Millersburg; **Lorain County** — James T. Stephens, Oberlin; **Medina County** — Richard W. Avery, Seville; Nevin J. M. Klotz and H. T. Pease, Wadsworth; Andrew J. Karson, Roland L. Mansell, and Frank C. Reutter, all of Medina; **Richland County** — Carroll E. Damron, C. Karl Kuehne and Carl M. Quick, all of Mansfield; **Wayne County** — Edward A. Gatz, Shreve and G. G. Stitzinger, Wooster.

OTHERS: Ernest B. Howard, Assistant Executive Vice-President, American Medical Association, Chicago; Mr. Joe D. Miller, Executive Director, American Medical Political Action Committee, Chicago; Mr. William R. Ramsey, Field Representative, American Medical Association, Chicago; R. Dean Dooley, Director, Physicians Relations' Department, Ohio Medical Indemnity, Inc., Columbus; Mr. Charles H. Coghlan, Executive Vice-President, Ohio Medical Indemnity, Inc., Columbus; Ralph E. Dwork, Director of Health, Ohio Department of Health, Columbus; and Messrs. Nelson, Saville, Page, Edgar, Moore, and Traphagan of the OSMA Headquarters Office.



*Meeting of Committees on Federal and State Legislation with County Chairmen and Members of Speakers' Bureau*



*Meeting of the OSMA Future Planning Committee*



*Meeting of Ohio Delegates and Alternate Delegates to the AMA.*

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## Changed Your Address? If So, Send the New One to Us Promptly

If you have moved, you will want *The Journal* and other OSMA mail mailed to your new address. Please use the coupon below to give us this information and mail the coupon to the Ohio State Medical Association, 79 E. State St., Columbus 15, Ohio, immediately as it takes several weeks to get our mailing list adjusted.

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# Medical Assistants' Programs . . .

## Ohio Organization Schedules Workshop and Annual Convention in Cleveland, Friday-Sunday, May 25-27

THE Ohio State Society of Medical Assistants has announced program features of its annual Education Workshop to be held in Cleveland, Friday, May 25, and the Annual Convention to be held Saturday and Sunday, May 26 and 27.

Reservations should be made not later than May 18 to Mrs. Dorothy Mapes, Room 304, 10515 Carnegie Avenue, Cleveland 6, Ohio. Registration for the Workshop, including luncheon and coffee, is $5.00. Registration fee for the Convention, including luncheon, banquet and breakfast, is $12.00.

Hotel reservations in the headquarters hotel should be sent direct to the Sheraton-Cleveland Hotel, 20 Public Square, Cleveland 13, Ohio.

Program features of the Friday Workshop, to be held in the Higbee Auditorium, Tenth Floor of the Higbee Company, have been announced as follows:

The morning program begins at 9:30 a. m. with an address of welcome by Mrs. Alison Noon, State educational chairman.

"Work, Exercise and the Heart," Dr. Herman K. Hellerstein, assistant professor of medicine, Western Reserve University School of Medicine.

"What the Endocrine Glands Mean to You," Dr. Victor Vertes, director, Metabolism and Endocrine Laboratory, Mount Sinai Hospital of Cleveland.

The afternoon program includes these features:

"The Child and the Surgeon," Dr. Robert J. Izant, Jr., assistant professor of pediatric surgery, Western Reserve.

Style show — "What the Well - Dressed Medical Assistant Should Wear," Miss Helen St. Andrews, fashion co-ordinator, Higbee Company.

### Saturday Morning

Theme of the Annual Convention at the Sheraton-Cleveland Hotel is "Towards Greater Understanding." Saturday's program includes the following features:

Address of welcome at 9:00 a. m. by Miss Helen Whitacre, president of OSSMA.

"The Community, Medicine and Survival in the '60's," Dr. John H. Davis, assistant professor of surgery, Western Reserve.

Panel Discussion entitled "Professional Relationships." Panel will include Dr. P. J. Robechek, past-president, Academy of Medicine of Cleveland; Dr. Samuel R. Gerber, Cuyahoga County coroner and associate in legal medicine at Western Reserve; Crawford Morris, attorney with the firm of Arter, Hadden, Wykoff and Van Duzer of Cleveland; and Edwin Ross, assistant director, University Hospitals of Cleveland.

At the luncheon, remarks will be made by Dr. Henry Crawford, president of the Academy of Medicine of Cleveland; Mrs. Lee Andrassy, president of the Cuyahoga County Medical Assistants Society; and by Mayor Anthony Celebrezze of Cleveland.

### Saturday Afternoon and Evening

The Saturday afternoon program includes the following features:

"Surgical Methods in Cancer Chemotherapy," Dr. Jerrel W. Benson, director of surgery, Highland View Hospital.

House of Delegates Meeting.

Discussion of the King Anderson Legislation, Dr. R. E. Tschantz, Councilor of the Sixth District, Ohio State Medical Association.

At the banquet following a cocktail hour, Robert Lang, executive secretary of the Academy of Medicine of Cleveland, will be master of ceremonies.

Evening speaker will be Dr. Robert A. Hingson, professor of anesthesia, Western Reserve, who will speak on "Crisis in Asia and Africa," relating experiences and observations on a recent trip as member of a commission to those areas.

The Sunday program begins with a breakfast at 10:00 a. m.

A representative of the American Association of Medical Assistants will give the Sunday welcome, followed by other program features to be announced.

* * *

Following are proposed amendments which will be voted on by the House of Delegates of the OSSMA at the Cleveland meeting:

### CONSTITUTION

**Present Article IX — Board of Directors:** "The Board of Directors of this society shall consist of the elective officers, the immediate past-president, one member from each component society, and one member from the membership-at-large."

**Proposed Amendment No. 1** as follows proposes a change in the representation on the Board for functional as

well as economic reasons. With the organization of more component societies, expenses and administrative duties increase. Since the Ohio State Medical Association has councilor districts, it seems to be a good division to follow for election to the Board of Directors of the Ohio State Society of Medical Assistants. Also, it proposes the establishment of an Executive Committee to facilitate the work of the Society.

"Be It Resolved, That Article IX of the Constitution be amended by deleting the present article and substituting the following:

"Board of Directors and Executive Committee"

"The Board of Directors of this society shall consist of the elective officers, the immediate past-president, and one member from each Councilor District of the Ohio State Medical Association who shall be a resident of the district for which she is nominated and elected."

"The Executive Committee of this society shall consist of the elective officers, the immediate past-president, and three other members of the Board of Directors elected to the Executive Committee annually by the House of Delegates."

"The Board of Directors shall have full authority and power of the House of Delegates between annual meetings, unless the House of Delegates shall be called into special session as provided elsewhere in the Constitution and Bylaws, but the Board of Directors shall take no action contravening any general policy which shall have been adopted by the House of Delegates and which at the time is still in effect.

"The Executive Committee shall conduct the business of this society between meetings of the Board of Directors and shall have the authority and power conferred on the Board of Directors by this Constitution and Bylaws but shall take no action contravening any general policy which shall have been adopted by the House of Delegates or the Board of Directors and which at the time is still in effect."

Proposed Amendment No. 2 as follows, would delete from present Article X the first paragraph of that article (this would be transferred to Article IX by amendment No. 1) and revise the balance of the article to provide for election of the Executive Committee:

"Be It Resolved, That Article X of the Constitution be amended by deleting the first paragraph and revising the second paragraph of that article to read as follows:

"Officers, directors and three members of the Executive Committee shall be elected by the House of Delegates during the annual meeting. If the office of the president becomes vacant the vice-president shall succeed to the presidency. The term of office of the recording secretary, the treasurer and members of the Executive Committee shall be for one year and the term of office of the members of the Board of Directors shall be for two years."

## BYLAWS

**Present Chapter III — "House of Delegates and Nomination and Election of Officers:** Section 4. Officers and members of the Board of Directors shall be nominated and elected at the annual meeting by the House of Delegates at its final session."

Proposed Amendment No. 3, reading as follows proposes the insertion of the words "and the Executive Committee":

"Be It Resolved, That Chapter III, Section 4 of the Bylaws be amended to read as follows:

"Officers and members of the Board of Directors and the Executive Committee shall be nominated and elected at the annual meeting by the House of Delegates at its final session."

**Present Chapter IV — "Duties of Officers and Directors,** Section 1. The duties of the officers shall be such as is implied by their respective offices and consistent with standard parliamentary procedure."

"President: The president will preside at annual meetings, and special meetings. She will appoint with the approval of the Board of Directors all committee chairmen. Be ex-officio member of all standing committees. Cast deciding vote in case of a tie. Appoint the Corresponding Secretary for the term of one year, such appointment to be announced at the last business session of the annual convention. Appoint a historian and parliamentarian.

"President-Elect: The president-elect shall assume the office of president at the end of the annual meeting. She shall serve as Chairman of the Education Committee.

"Recording Secretary: The duties of the Recording Secretary shall be to keep the minutes of the annual meeting and any other special meeting pertaining to the society. To report the minutes to the annual meeting. To maintain lists of officers and members of the society. To preserve all important documents.

"Treasurer: The treasurer shall be custodian of all monies, securities and valuable papers of the Society. She shall pay all authorized obligations of the society by voucher check countersigned by the President. She shall keep a detailed account of the receipts and disbursements and make an annual written report to the meeting of the society. Records shall be available for audit at the request of the Board of Directors. She shall be under a surety bond to be paid by the Ohio State Society of Medical Assistants.

"Board of Directors: The Board of Directors shall conduct the business of the Society between annual meetings. It shall be empowered to employ secretarial assistance at such time as is deemed advisable and financially sound. It shall submit a report of its activities through the president to the House of Delegates at its annual meeting. It shall fill vacancies occurring among officers."

Proposed Amendment No. 4, reading as follows, describes the duties of the vice-president and revises the duties of president-elect and clarifies other duties of officers of the society, if proposed amendments should be passed.

"Be It Resolved, That, Chapter IV, Section I of the Bylaws shall be amended as follows:

"(1) By inserting the following after the first paragraph:

"Specifically, the duties of such officials shall be as follows:"

"(2) By inserting the following after the paragraph dealing with duties of the President:

"Vice-President: The vice-president shall assist the president in her duties throughout the year. She shall assume the duties of the president in the absence of the president.

"(3) By revising the following existing paragraphs to read as follows:

"President-Elect: The president-elect shall assume the office of the president at the end of the annual meeting. She shall serve as Chairman of the Education Committee and Co-Chairman of the Convention Committee.

"Board of Directors: The Board of Directors shall have full authority and power of the House of Delegates between annual meetings within the limitations imposed by Article IX of the Constitution. It shall submit a report of its activities through the president to the House of Delegates at its annual meeting. It may fill vacancies as provided in Chapter III.

"Executive Committee: The Executive Committee shall conduct the business of the Society as prescribed in Article IX of the Constitution, seeking the advice of the Ohio State Medical Association advisors. It shall submit reports of its activities through the President to the Board of Directors at each meeting of the Board. It is empowered to employ secretarial assistance at such times as is deemed advisable and financially sound."

Proposed Amendment No. 5, as follows, proposes that the Editor of the OSSMA Bulletin shall attend the meetings of the Board of Directors, by the addition of Section 4:

"Be It Resolved, That, Chapter IV of the Bylaws be amended by the addition of Section 4, reading as follows: Section 4. The Editor of the OSSMA Bulletin shall attend all meetings of the Board of Directors without voting privileges."

**Present Chapter V — Committees, Section 1.** "The standing committees, which shall be appointed by the President for a term of one year, and shall consist of not less than five members each shall be the following: Membership, Budget and Finance, Constitution and Bylaws, Education,

Publicity, Ways and Means, Credentials, Civil Defense and Nominating."

Proposed Amendment No. 6, as follows, proposed a change in the appointment of the members of the Budget and Finance Committee. If adopted in 1962, appointments of the three members shall be for one, two and three years terms on the proposed change:

"Be It Resolved, That, Chapter V, Section 1 of the Bylaws be amended by deleting the first paragraph and substituting the following: The standing committees, which shall be appointed by the president for a term of one year, and shall consist of not less than five members each, shall be the following: Membership, Constitution and Bylaws, Education, Publicity, Ways and Means, Credentials, Civil Defense and Nominating. The Budget and Finance Committee shall be composed of the treasurer and immediate past-president and three members appointed by the president for a term of three years. The functions of the various committees shall be as follows:

Present Chapter V — Committees, Section 1, b. "Budget and Finance: The Budget and Finance Committee shall prepare a budget for the ensuing year and present the same for the consideration of the Board of Directors. It shall act as an advisory committee to the Board on financial matters. It shall present recommendations for augmenting the funds of the society whenever the need arises. The treasurer shall be one of the five members of this committee."

Proposed Amendment No. 7, as follows, for clarification under special committee, even though there is some repetition.

"Be It Resolved, That, Chapter V, Section 1, (b) of the Bylaws be amended as follows: Budget and Finance: The Budget and Finance Committee shall prepare a budget for the ensuing year and present the same for the consideration of the Board of Directors. It shall act as an advisory committee to the Board on financial matters. It shall present recommendations for augmenting the funds of the society whenever the need arises. The treasurer and immediate past-president shall be two of the five members of this committee. The term of office of the three appointed members shall be for three years, with the term of one member expiring each year."

Present Chapter V — Committees, Section 1, (f) "Ways and Means: This Committee shall become one of the Standing Committees of the Ohio State Society of Medical Assistants. Its duties shall be to draw up and submit to the Board of Directors a method of augmenting State funds such as Workshops, Symposiums, State Stationery, State Pins, for a profit to OSSMA and it shall work in conjunction with the Convention Committee for this purpose."

Proposed Amendment No. 8, as follows, proposes revision of the duties of the Ways and Means Committee, inasmuch as there is an annual Workshop and Pin Chairman.

"Be It Resolved, That, Chapter V, Section 1, (f) of the Bylaws be amended by deleting the present wording and substituting the following: Ways and Means: This Committee shall become one of the Standing Committees of the Ohio State Society of Medical Assistants. Its duties shall be to draw up and submit to the Board of Directors a method of augmenting State funds to OSSMA and it shall work in conjunction with the Convention Committee for this purpose."

## Lithuanian-American Physicians Elect Officers for Year

The Lithuanian American Medical Association of Ohio met recently and elected the following officers for 1962: President, Dr. Jonas Stankaitis, 15821 Cleviden Rd., Cleveland 12; vice-president, Dr. Henry Brazaitis, Wickliffe; treasurer, Dr. Edmundas Lenkauskas, Cleveland; secretary, Dr. Daniel Degesys, 10612 Lake Shore Blvd., Cleveland 8. Immediate past-president is Dr. Vladas Ramanauskas, Cleveland.

## Special Rates on AMA Publications Offered To Certain Members

A report from the American Medical Association states that in order to encourage AMA dues exempt and AMA associate members to continue or order new subscriptions for AMA publications, both of these classes of members are now eligible for the 50 per cent subscription rates. Active dues exempt and associate AMA members are being notified by the AMA office of these special rates when their 1962 membership cards are released. Order should be mailed direct to the American Medical Association, Circulation and Records Department, 535 N. Dearborn St., Chicago 10, Ill., with check and names of publications desired.

Regular and 50 per cent rates for AMA Publications are listed below:

| *Name of Periodical* | *Regular Rates (U.S., Poss. & Canada)* | | *Special 50% Rates (U.S., Poss. & Canada)* | |
|---|---|---|---|---|
| | *1 yr.* | *2 yrs.* | *1 yr.* | *2 yrs.* |
| Journal AMA | $15.00 | $23.00 | $7.50 | $11.50 |
| AMA News (Free) | | | | |
| Today's Health | 4.00 | 6.00 | 2.00 | 3.00 |
| Amer. Jr. of Dis. of Child. | 8.00 | 12.00 | 4.00 | 6.00 |
| Arch. of Dermatology | 8.00 | 12.00 | 4.00 | 6.00 |
| Arch. of Environmental Health | 8.00 | 12.00 | 4.00 | 6.00 |
| Arch. of General Psychiatry | 8.00 | 12.00 | 4.00 | 6.00 |
| Arch. of Internal Medicine | 8.00 | 12.00 | 4.00 | 6.00 |
| Arch. of Neurology | 8.00 | 12.00 | 4.00 | 6.00 |
| Arch. of Ophthalmology | 8.00 | 12.00 | 4.00 | 6.00 |
| Arch. of Otolaryngology | 8.00 | 12.00 | 4.00 | 6.00 |
| Arch. of Pathology | 8.00 | 12.00 | 4.00 | 6.00 |
| Arch. of Surgery | 8.00 | 12.00 | 4.00 | 6.00 |

## College of Medicine at Ohio State Announces Future Programs

The Ohio State University College of Medicine will sponsor or co-sponsor a number of postgraduate programs in coming months. The following were announced to *The Journal:*

May 3 - 4 —Basic Science Conference in Orthopedics.

May 25-26—Radioisotope Kidney Function Disease.

June 22 — Psychiatry Seminar.

August 29 - 30 —Conference on Athletic Injuries.

September 10 - 14 — Aviation Medicine.

September 21 - 22 — Diagnosis and Treatment in Gastroenterology.

September 28 - 29 — Pulmonary Disease Postgraduate Course.

October 10 — Seventh Annual Session on Rheumatic Diseases.

Additional information on these courses may be obtained from John A. Prior, M. D., assistant dean of the College of Medicine and director of the Center for Postgraduate Medical Education, Ohio State University College of Medicine, Columbus 10, Ohio.

In Our Opinion

# Comments on Current Economic, Social And Professional Problems

### MAY 8 — AN IMPORTANT DAY FOR GOOD CITIZENS

Primary Election Day in Ohio will be May 8. Every Ohio physician as a good citizen should make it his business to find out everything he can about the candidates who are running for nomination on the ticket of his political party.

The time to start picking able men and women for political offices is in the party primaries. If poor candidates are selected in each primary, then the voter in November will have nothing better than a Hobson choice.

Get busy. Find out about the candidates. How do they stand on medical matters? What is their philosophy of government, economics, social questions, etc.? Support those who measure up. This is serious business as destiny can be decided by those holding public office.

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### TELL YOUR PATIENTS WHAT COULD HAPPEN

Are you talking to your patients about the inherent dangers of H. R. 4222, the King-Anderson Bill? If you are (we hope you are), here's a hunch on one approach which you may not be using.

Ask them if they believe the nation's wage earners should be taxed to pay for the limited health care of millions of people who do not need financial help. Tell them that you want to continue to serve your patients to the best of your ability, regardless of age or income, but that you won't be able to do so if your decisions are regulated by government administrators. Suggest that they write their congressmen and state factually their objections to the proposal now in Congress.

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### COST ALONG WITH NEED SHOULD BE CONSIDERED

In our opinion, the project at Jefferson Medical College Hospital to get medical students to consider the cost as well as the need before ordering diagnostic tests for hospitalized patients is one which ought to be repeated again and again throughout the country. In fact, physicians in practice should sit up and take more note of this particular subject.

The program was written up in Hospitals, magazine of the American Hospital Association by Dr. William A. Sodeman, dean of the College, and John Nelson, formerly assistant director of the hospital. The authors in summary said the program serves "not only to acquaint students with the costs of patient care, but also to stimulate them to consider, through realization of charges, the need for the procedure or service under discussion . . . Real benefits in evaluation of indications for, and selection of, alternative procedures resulted."

Necessary diagnostic procedures must be ordered by the physician, of course. However, he must be sure that all or part of them are necessary. Ordering of wholesale diagnostic tests without rhyme or reason plays into the hands of those who charge that medicine is so costly that it must become a governmental service or utility.

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### SOUND ADVICE FOR THE MEDICAL WITNESS

Here's good advice for the medical witness:

"If you are unable to express a professional opinion —don't express one—do not allow your good testimony to be destroyed by making statements you must later qualify or retract."

So spoke W. E. Shissler, Harrisburg, Pa., attorney before a medical county medical society. Keep this in mind next time you're on the stand.

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### COURT OPINION SERVES AS WARNING TO PHYSICIANS

The Court of Appeals for Franklin County in Opinion No. 6503 held that Rule No. 6 of the Industrial Commission, providing that "fee bills for medical, hospital and nursing services and for medicines and appliances, are forever barred from payment unless they are filed within two years from the time such services were supplied" is valid and does not deny or unreasonably restrict any rights of a claimant.

In its opinion, the court points out that the claimant can protect his interests in a medical award by attaching bills for medical services rendered to his claim application. At the same time, the court raises some questions regarding the policy of the commission in permitting the "direct filing by creditors."

This case should serve as a warning to physicians. Each should get his Workmen's Compensation fee

bills filed promptly—certainly well within the two-year limitation. Should unnecessary delays on the part of physicians cause unnecessary trouble for claimants and cause unnecessary confusion in the procedures of the Bureau of Workmen's Compensation, steps might be taken to eliminate the rule allowing creditors (physicians) to file their fee bills directly with the Bureau. Obviously, this would not be desirable. It would be far better for the physician to have control over the filing of his fee bills than to rely on claimants to do so.

### MEDICAL SCHOOLS DON'T GROW ON BUSHES

As a footnote to the active discussions now going on in many states, including Ohio, as to how to increase medical education facilities are data from the AMA Council on Medical Education concerning the life and death of medical schools.

The mortality rate of medical schools in the U. S. has been 80 per cent. Of the 444 medical schools which have been organized in this country, only 86 (20 per cent) still are in existence. The death rate was especially high during the period 1875 to 1925 when 81 per cent of the schools expired. Reasons given for closures were: (1) the market was saturated about 1900 as there were 165 schools and a population of only 75 million; (2) wave of reform in medical education. It is interesting to note that 173 or 40 per cent of all medical schools organized were located in four states which now have only 21 schools or 12 per cent of the existing total, namely: Illinois, 45; Missouri, 44; New York, 43 and Ohio, 41.

These figures are not presented with the intent of discouraging well-conceived efforts to expand the number of medical schools. Prospects for an increase within the next few years are good. However, those behind such efforts should not mislead themselves or the public. Medical schools adequate to meet modern conditions don't grow on bushes and once erected can't exist on shoe-string financing.

### TAXES AND THE PROFESSIONAL AND SERVICE GROUPS

Stanley J. Bowers, state tax commissioner, has tossed a puzzler. Recently, in advocating study of the need for an income tax in Ohio, Mr. Bowers is reported to have said: "This would reach a source we do not have today. We haven't any tax structure which reaches the professional and service groups."

True, as Mr. Bowers states, an income tax would reach a source which is not reached today. But, why single out especially the professional and service groups? Does Mr. Bowers believe they do not pay real estate taxes, intangible taxes and sales taxes to the State of Ohio the same as any other group of citizens?

Obviously, current and future tax studies will bear careful watching.

# Buckeye News Notes...

**Akron**—Dr. I. Richard Birnbaum has been named winner of the 1962 Akron Brotherhood Award. The presentation of the award was made at the seventh annual Akron Area Brotherhood Dinner at the Central YMCA by Mayor Edward Erickson.

**Cincinnati**—The merits of two federal programs for medical aid for the aged were debated recently at the First Unitarian Church, Cincinnati.

**Cleveland**—The medical staff of St. Vincent Charity Hospital honored Dr. Edward P. Monaghan and Dr. Fred C. Oldenburg recently for having served on the hospital staff more than 50 years. Dr. Earle B. Kay, chief of staff, presented gold cups to these doctors at the annual medical staff dinner in the Cleveland Athletic Club.

**Columbus**—In cooperation with the American Cancer Society, the surgical staff of Mt. Carmel Hospital sponsored a "Clinic on Malignancy," on March 10 in the Mt. Carmel School of Nursing Auditorium. The clinic featured Dr. Donald B. Effler, chief of the Department of Thoracic Surgery at the Cleveland Clinic Foundation.

**Franklin**—Dr. R. W. Gifford, Jr., a member of the staff at the Cleveland Clinic, was the featured speaker at a recent meeting of the Franklin Rotary Club. Dr. Gifford related his experiences as Assistant Physician to Congress while a member of the U. S. Navy.

**Fremont**—Dr. Frank L. Moore, a practicing physician for more than 50 years, has been named Sandusky County Citizen of the Year. Dr. Moore was given the Howard E. Zink award at the annual meeting of Chamber of Commerce.

**Galion**—The role of industrial medicine was explained by Dr. H. R. Imbus when speaking before a recent dinner meeting of the Galion Rotary Club. Dr. Imbus' topic was "Occupational Health and Safety Programs in Industry."

**Plymouth**—Dr. Darrell B. Faust, the community's only physician, was honored recently by the Plymouth Chamber of Commerce as the community's outstanding citizen for 1961.

**Springfield**—Dr. Richard L. Meiling, dean of the college of medicine at Ohio State University and former director of medical services for the U. S. Department of Defense, was the speaker March 15 when Wittenberg University held a dinner meeting for medical men of the Springfield area. Dr. Meiling spoke on the subject "The Doctor's Role in a Changing World."

**Wilmington**—Three Wilmington doctors, Foster J. Boyd, Richard R. Buchanan and E. K. Yantes, discussed medical care for the aged at a recent Rotary luncheon at the General Denver Hotel.

*a medical milestone at America's crossroads*

# AMA 111th Annual Meeting

**CHICAGO'S MAGNIFICENT McCORMICK PLACE • JUNE 24-28, 1962**

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★ Over 700 exhibits staffed by top researchers and expert technologists

★ Surgical innovations and symposia on live color TV and motion picture premieres

★ Special daily features representing each medical discipline—and countless other vital programs to serve you in your practice

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535 North Dearborn Street, Chicago 10, Illinois

See JAMA May 19 for complete scientific program... for physician advance registration and hotel reservation forms

# Do You Know? . . .

"Suggestions for a Community Home Care Program" is latest publication of the OSMA. Prepared by Committee on Care of Aged, after consultation with many other health groups, this pamphlet has been sent to all County Medical Societies as a guide. Copies are being distributed by many other interested organizations.

* * *

Do you know that most of the insurance companies writing professional liability insurance now provide in their policies that the physician-policyholder is protected, if sued, because of a decision he may make while serving in an official capacity in his medical society or on a hospital committee? This is an important development for all physicians.

* * *

Members of OSMA Committee on Radiation have been named as a medical advisory committee to Ohio Department of Health on radiation matters.

* * *

Ohio's contribution to American Medical Education Foundation in 1961 totaled $63,177, a record-breaking amount from 2,073 donors, compared to $53,919 by 1,317 donors in 1960. Direct gifts by Ohio doctors to own schools not known yet.

* * *

Dr. Paul F. Orr, Perrysburg, Chairman of the OSMA Committee on Hospital Relations, has accepted appointment for the second year as a member of The National Foundation for Medical Scientific Research, Professional Education and Medical Care's Health Scholarship Committee. Dr. Orr represents Ohio on this committee.

* * *

Henry Luidens, mental hygiene commissioner, appointed Dr. John T. Toppen to be superintendent of Longview State Hospital, Cincinnati. Dr. Toppen succeeds Dr. Charles D. Feuss who resigned to open private practice of psychiatry.

* * *

Dr. Winslow J. Bashe Jr., chief of the Division of Communicable Diseases, State of Ohio, Department of Health, spoke at a recent meeting of the Fort Steuben Academy of Medicine. Dr. Bashe's topic was "Medical Care and Treatment of Syphilis."

* * *

Dr. William S. Smith, Columbus, has been appointed by the State Medical Board as a member of the board's advisory committee for physical therapy, for a term of three years ending December 31, 1964. The other physician member of the committee is Dr. Ernest Johnson, Columbus.

Dr. Albert B. Sabin, Cincinnati, recently addressed the Royal Society of Health in London, England, where he reported recent results, and recommended optimum use of oral poliovirus vaccine.

* * *

The Cancer Cytology Foundation of America estimates that 9000-10,000 deaths among women could be prevented each year if all women over 20 would see their doctor once a year for a vaginal smear test for cervical cancer and if all women patients would use this test routinely.

* * *

Physicians interested in examinations and requirements for certification by the American Board of Obstetrics and Gynecology are invited to contact the Executive Secretary of the Board, Robert L. Faulkner, M. D., 2105 Adelbert Road, Cleveland 6, Ohio.

**Do You Know? . . .**

**That at the end of 1961 an estimated 136 million Americans had hospital insurance, an increase of four million over the year before.**

**That 124 million persons had surgical insurance, or three million more than at the end of 1960.**

**That 91 million persons had regular medical insurance, three-and-one-half million more than in 1960.**

**That 35 million persons had major medical insurance, a rise of more than seven million for the largest increase of all health coverages.**

**That 43 million persons had loss-of-income insurance, an increase of 600,000.**

**That voluntary health insurers paid out an estimated $6.3 billion in benefits during 1961, an 11 per cent increase over 1960.**
***—Source: Health Insurance Institute.***

Dr. Charles H. Rammelkamp, Jr., professor of medicine at Western Reserve University and director of research for Cleveland City Hospital, is one of 10 medical scientists to receive the Distinguished Achievement Award presented by the editors of Modern Medicine.

* * *

The U. S. Department of Health, Education and Welfare has announced that it will conduct a study in Cincinnati to determine the role of automobiles in polluting air in American cities.

# Ad Astra

John Alargo Alexander, M. D., Cleveland; Maharry Medical College, 1931; aged 59; died February 1; member of the Ohio State Medical Association and recent member of the American Medical Association; member of the National Medical Association. Dr. Alexander began practice in Cleveland in 1937, later specializing in otolaryngology. During World War II, he served in the Army Medical Corps, attaining the rank of captain. Organizations to which he belonged included the Elks and the Prince Hall Affiliation of Masons. Survivors include his widow and a sister.

Stephen Richard Beluk, M. D., Cleveland; Indiana University School of Medicine, 1943; aged 48; died January 30; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Gary, Ind., Dr. Beluk had been a general practitioner in the Cleveland area since the middle 1940's. He is survived by his widow, a son, two daughters, his mother, two sisters and two brothers.

Herbert Conrad Boehner, M. D., Cincinnati; University of Cincinnati College of Medicine, 1934; aged 54; died February 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Boehner served virtually all of his professional career in the Cincinnati area. An outdoor and sports enthusiast, he was for many years team physician for the Cincinnati Reds. Other affiliations include membership in the Ohio Historical and Philosophical Society. Surviving are his widow, a sister and three brothers.

Ovid Owen Burt, M. D., Londonderry; Ohio State University College of Medicine, 1933; aged 57; died February 1; member of the Ohio State Medical Association, the American Medical Association and the American Association of Physicians and Surgeons. Member of a pioneer family of the Ross-Vinton County area, Dr. Burt practiced medicine in that vicinity for about 28 years. He was also a breeder of cattle and horses and among affiliations belonged to the Elks Lodge and the Evangelical United Brethren Church. Surviving are his widow, two sons, three daughters, three stepchildren, four sisters and three brothers. One brother is Dr. Olan Burt of Columbus.

Guy Victor Crouse, M. D., Arcadia, Calif. (formerly of Cleveland); Western Reserve University School of Medicine, 1920; aged 70; died February 16; former member of the Ohio State Medical Association. Dr. Crouse moved to California in 1950 after practicing many years in Cleveland. He is survived by his widow, a son and a brother.

James Thomas Duhigg, M. D., Cleveland; University of Illinois College of Medicine, 1905; aged 80; died February 17. A native of Des Moines, Dr. Duhigg opened an office in Cleveland in 1923. A member of the Catholic Church, he is survived by his widow, five sons and a sister. Dr. William J. Duhigg, also of Cleveland, is one of his sons.

Thurman R. Fletcher, M. D., Columbus; Ohio State University College of Medicine, 1909; aged 73; died February 2; member of the Ohio State Medical Association, the American Medical Association and the Radiological Society of North America. Dr. Fletcher's professional career extended over a period of 52 years. He was a member of the Mercator Club, and several Masonic bodies. Survivors include his widow, three daughters, a brother and a sister.

John Paul Goetz, M. D., Akron; Western Reserve University School of Medicine, 1928; aged 59; died February 6; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Goetz practiced medicine in Akron for 32 years, with time out for service in the Army Medical Corps during World War II. He is survived by his widow and a son.

John Bennett Hanson, M. D., Ft. Lauderdale, Fla.; Western Reserve University School of Medicine, 1916; aged 72; died February 28. Former Cleveland physician, Dr. Hanson was surgeon for the New York Central System and operated a private hospital. He was a member of the Masonic Lodge. Surviving are his widow, a daughter, a son and two sisters.

Joseph David Heiman, M. D., Cincinnati; University of Michigan Medical School, 1921; aged 65; died February 7; member of the Ohio State Medical Association, the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. Native of Butte, Montana, Dr. Heiman devoted many years to practice in Cincinnati where he was one of the founders and the first president of the Cincinnati Surgical Society, and a member of the University of Cincinnati College of Medicine faculty. A 32nd Degree Mason and

member of the Rockdale Avenue Temple, he is survived by his widow, a daughter and a brother.

**Robert L. Lockhart,** M. D., Cleveland; University of Louisville School of Medicine, 1906; aged 79; died February 27; former member of the Ohio State Medical Association. Dr. Lockhart moved to Cleveland in 1920 to accept appointment as Cuyahoga County health commissioner, a post he held for many years. He was previously on the staff of the Ohio Department of Health in Columbus. Other appointments included that as health director in Cleveland Heights. He retired some years ago for health reasons. Among survivors are his widow and a daughter.

**Victor Louis Magers,** M. D., Tiffin; Ohio State University College of Medicine, 1909; aged 77; died February 19; member of the Ohio State Medical Association and the American Medical Association. A native of Tiffin, Dr. Magers practiced there for more than a half century. He was a veteran of World War I, having served in the Army Medical Corps. A member of the Catholic Church, the Knights of Columbus and the Holy Name Society, he is survived by his widow and a sister.

**Walter Wathen Meade,** M. D., Bicknell, Ind.; Eclectic Medical College, Cincinnati, 1929; aged 58; died December 28. Dr. Meade practiced for a number of years in New Richmond, Clermont County, before he moved to Indiana in 1941. He is survived by his widow, two sons and a sister.

**Henry Leon Muckleroy,** M. D., Marysville; Howard University College of Medicine, 1910; aged 84; died February 18; member of the National Medical Association. Dr. Muckleroy practiced for many years in Muskogee, Okla., before coming to Ohio. He is survived by his widow, four sisters and two brothers.

**Edward Louis Robinson,** M. D., Hamilton; University of Cincinnati College of Medicine, 1937; aged 50; died February 6; member of the Ohio State Medical Association and American Medical Association; diplomate of the American Board of Pediatrics. A native of Hamilton, Dr. Robinson opened an office there after World War II, during which he served in the Army Medical Corps, attaining the rank of Major. Active in children's programs such as that promoted by the National Foundation, Dr. Robinson was a member of the Catholic Church and the Knights of Columbus. He is survived by his widow, two sons, two daughters and a brother.

**Sigmund Paul Rose,** M. D., San Mateo, Calif. (formerly of Dayton); Howard University College of Medicine, 1942; aged 47; died February 15; former member of the Ohio State Medical Association, and late a member of the California Association; member of the American Medical Association; diplomate of the American Board of Internal Medicine. A native of New York City, Dr. Rose practiced in Dayton for about 15 years before moving to California in 1960. He is survived by his widow, four sons, his mother, four sisters and five brothers.

**Archie Francis Schultz,** M. D., Fremont; Indiana University School of Medicine, 1916; aged 72; died February 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Schultz opened an office in Fremont shortly after serving in the Army Medical Corps during World War I. After many years of private practice, he went into health work, serving as city and county health commissioners. A former president of the local Country Club, he was active in numerous affairs such as the work of the Methodist Church. Survivors include his widow, and three sons.

**Otto Jay Swisher, Jr.,** M. D., Columbus; Ohio State University College of Medicine, 1927; aged 61; died February 17. Dr. Swisher was former director of the Division of Industrial Hygiene of North Carolina and was a veteran of World War II. He was a member of the American Legion, several Masonic bodies and the Evangelical and Reformed Church. Survivors include his widow, a daughter, his mother, a brother and a sister.

**Albert Edmund Winston,** M. D., Steubenville; Western University School of Medicine, 1918; aged 68; died February 21; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A practicing physician in Steubenville for 40 years, Dr. Winston was associated with numerous professional and community projects. He was active in organization of the internship program at Ohio Valley Hospital, in the local cancer registry program, the outpatient department at the hospital, organization of the Fort Steuben Academy of Medicine and other programs. In addition to profession associations, he was a member of the Presbyterian Church, the Rotary Club, and the Elks Lodge. Survivors include his widow, a daughter, a son and a brother.

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## "Long Term Patient Care" Subject of Program

A conference on the subject, "Long Term Patient Care," will be held at the Veterans Administration Hospital, 3200 Vine Street, Cincinnati 20, on Thursday and Friday, April 26 and 27, under joint sponsorship of the Cincinnati Hospital Council and the VA Hospital. The program opens at 8:00 a. m. on Thursday and concludes at noon on Friday.

An outstanding faculty has been announced including visiting authorities in the field as well as local staff members. Chairman for the institute is Dr. Gerald L. Baum, associate chief of staff, VA Hospital. Additional information may be obtained from Dr. Baum at the foregoing address.



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In diarrhea this lowered propulsion permits a physiologic absorption of excess fluid, lessens frequency and fluidity of stools and gives safe, selective, symptomatic control of most diarrheas. Concurrently, it conserves electrolytes and controls cramping.

Investigators have found the antidiarrheal action of Lomotil not only "excellent"[2] but "efficacious[3] where other drugs have failed. . . ."

**DOSAGE:** For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

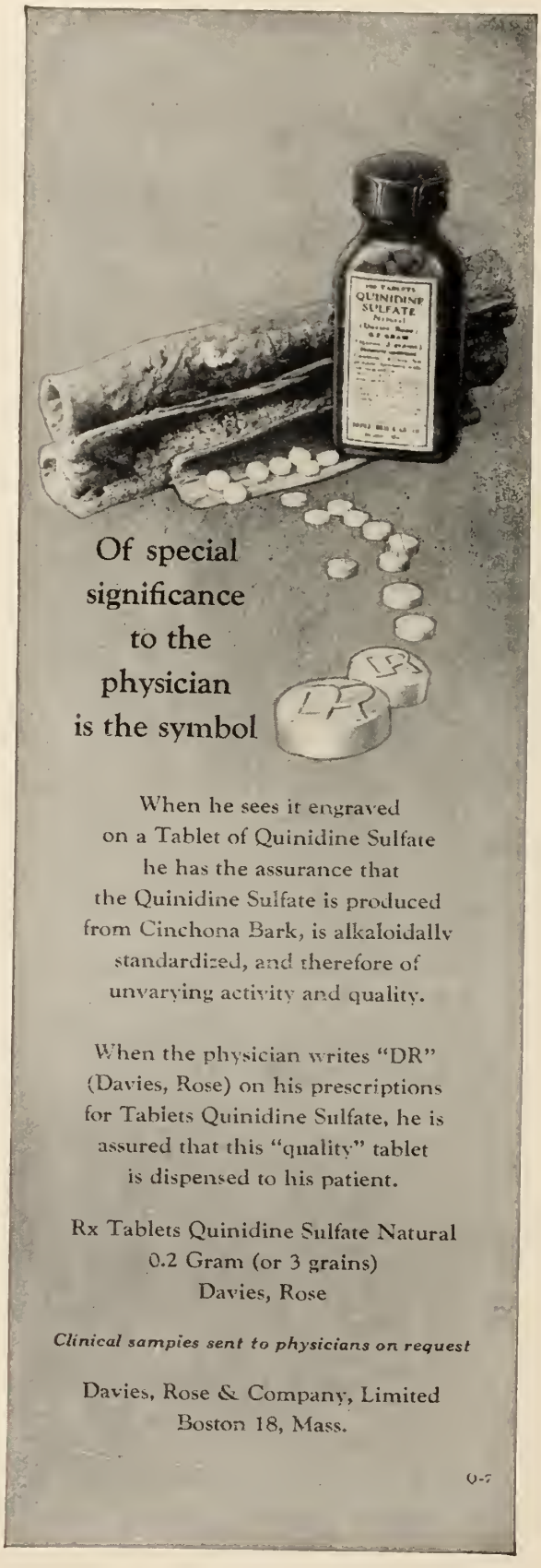
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1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.; Weiss, J., and Siman, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.


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# New Members . . .

The following are the names of the new members of The Ohio State Medical Association since February 1, 1962. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Allen County**
Clyde W. Conger, Lima
Robert A. Watts, Lima

**Cuyahoga County**
Alan R. Alexander, Cleveland
Emilia C. Allen, Cleveland
Earl R. Berger, Cleveland
Romulo Z. Carrillo, Cleveland
Bernard C. De Leo, Cleveland
C. Northcott Hinman, Cleveland
Paul Kassay-Farkas, Cleveland
Harry B. Leslie, Jr., Cleveland
William M. Michener, Cleveland
Allan Z. Schwartzberg, Cleveland
Donald W. Shanabrook, Cleveland
William J. Teknipp, Cleveland
John M. Van Fossen, Richfield

**Delaware County**
Lloyd P. May, Delaware

**Hamilton County**
Robinson P. Kirkpatrick, Cincinnati
Peter G. Petrou, Cincinnati
Warden M. Rimel, Cincinnati
Morris L. Stein, Cincinnati
Robert L. Stewart, Cincinnati
Aaron S. Weinstein, Cincinnati
Karl Ziesmann, Cincinnati

**Lucas County**
Phillip Horowitz, Toledo
Thomas G. Klever, Toledo
Robert E. Roberts, Toledo

**Mahoning County**
Skevos M. Zervos, Youngstown

**Miami County**
Robert R. C. Buchan, Troy
Kenneth J. Faze, West Milton

**Montgomery County**
Gerald H. Dennis II, Englewood
Gregory G. G. Young, Dayton

**Stark County**
Annemarie Haiss, Alliance

**Summit County**
Jerome J. Berner, Barberton
Charles L. Henault, Cuyahoga Falls
Martha Jane D. Nelson, Cuyahoga Falls
Harold G. Niemeyer, Akron
James W. Singer, Akron
James H. Watson, Akron

## Urology Department at Ohio State Offers Radioisotope Program

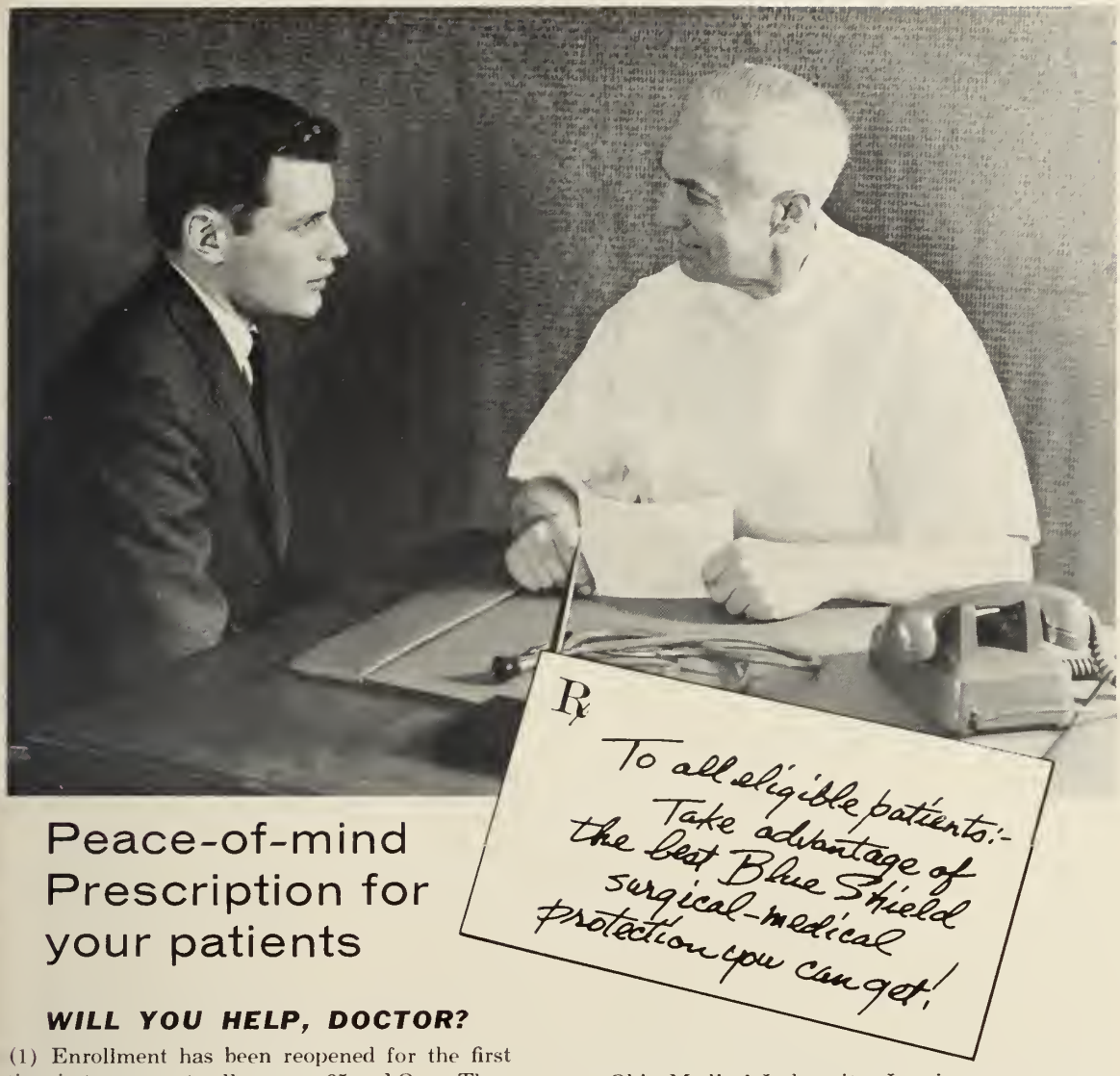
Announcement has been made of a Conference on Radioisotope Applications and Tests of Kidney Function, May 25-26, sponsored by the Ohio State University College of Medicine, Postgraduate Medicine Department.

The subjects include the latest techniques, procedures and results of: The Radioisotope Renogram, Surgical Renography, the Radioisotope Renal Clearance Test, the Radioisotope Blood Clearance Test, the Radioisotope Vesical Residual Test, the Radioisotope Vesical-ureteral Residual Test and Tape Recording, Logarithmic and Linear Rate Meter Applications. An outstanding faculty has been announced.

The conference should be of interest to personnel in Radioisotopes, Radiology, Internal Medicine, Urology and Electronics, Chester C. Winter, M. D., Chief, Division of Urology, announced. The registration fee is $20.00. The meeting will be held in the Ohio Union on the Ohio State University Campus and The Center for Postgraduate Medical Education may be contacted for further information.

---

Another in the series of regular seminars, sponsored by the Southwestern Ohio Society General Physicians, was held recently at the Cincinnati College of Medicine. The topic of discussion was "Arthritis and Related Conditions."




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800,000 are members of payroll deduction groups and have the PREFERRED Plan. They are eligible for the modern, more adequate MAJOR Plan.

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# Activities of County Societies . . .

## First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

### HAMILTON

At its March meeting, The Academy of Medicine of Cincinnati in cooperation with The Cincinnati Surgical Society heard Dr. Richard L. Varco, professor of surgery at the University of Minnesota College of Medical Science. Dr. Varco's topic for the evening was "Principles and Practice in the Care of the Clean Surgical Wound."

Throughout the month, many specialty meetings were held.

* * *

The Academy of Medicine of Cincinnati announced recently that it is offering free family health records to Greater Cincinnati residents.

The 12-page booklets are published by the AMA and have spaces for family history, dates of immunizations, lists of diseases and illnesses, health and accident information, birth record data and other health information.

## Second District

(COUNCILOR: RAY M. TURNER, M. D., SPRINGFIELD)

### CLARK

Dr. John Campbell, professor of radiology at the University of Indiana Medical School, Indianapolis, spoke at the monthly dinner meeting of the Clark County Medical Society. Dr. Campbell's topic was "Cine-Fluoroscopy." — *The Springfield News-Sun.*

* * *

At the February luncheon meeting of the Clark County Ministerial Fellowship, Dr. Howard H. Ingling spoke on "Our Spiritual Ministry to the Sick." — *The Springfield News-Sun.*

### GREENE

Dr. Charles G. Lovingood, Dayton, was the principal speaker at the February meeting of the Greene County Medical Society. Dr. Lovingood's topic was "Evaluation of Arterial Graft."

Dr. Ray M. Turner of Springfield, OSMA second district councilor, spoke briefly to the group on matters pertaining to the state organization. — *The Xenia Daily Gazette.*

### MIAMI

Dr. Frederick Good of Dayton spoke on the subject of hand injuries at a recent meeting of the Miami County Medical Society.

Names of the following chairmen of standing committees for 1962 have been announced: legislative, Dr. W. W. Trostel; rural health, Dr. E. T. Pearson; grievance, Dr. Harry Shilling; industrial health, Dr. Maynard C. Kiser; traffic safety, Dr. George Woodhouse; Civil Defense, Dr. Joseph E. Bausman; public relations, Dr. Edmund Saunders; school health, Dr. Kurt C. Becker; maternal health, Dr. Harold Foss; American Medical Education Foundation, Dr. W. T. Wilkins; cancer, Dr. Ramen Das; advisory committee to the Woman's Auxiliary to the Miami County Medical Society, Dr. Conrad Clippinger. — *The Troy Daily News.*

### MONTGOMERY

The Fourth Annual Cardiac Conference of Good Samaritan Hospital was again this year conducted with the cooperation of the Montgomery County Medical Society. Guest speakers at this year's conference were Dr. Irvine Page, Director of Research at the Cleveland Clinic and Dr. Charles Hufnagel, Professor of Surgery at Georgetown University, Washington, D. C. Dr. Page spoke on "Atherosclerosis as of February 1962" and Dr. Hufnagel spoke on "The Surgical Treatment of Aortic Valve Disease."

## Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

### ALLEN

Dr. Herman K. Hellerstein, heart ailment researcher, discussed "Physical Training, Emotional Stress and Coronary Artery Disease" at a recent meeting of the Lima and Allen County Academy of Medicine. The meeting was co-sponsored by the Lima Academy of General Practice. — *Lima News.*

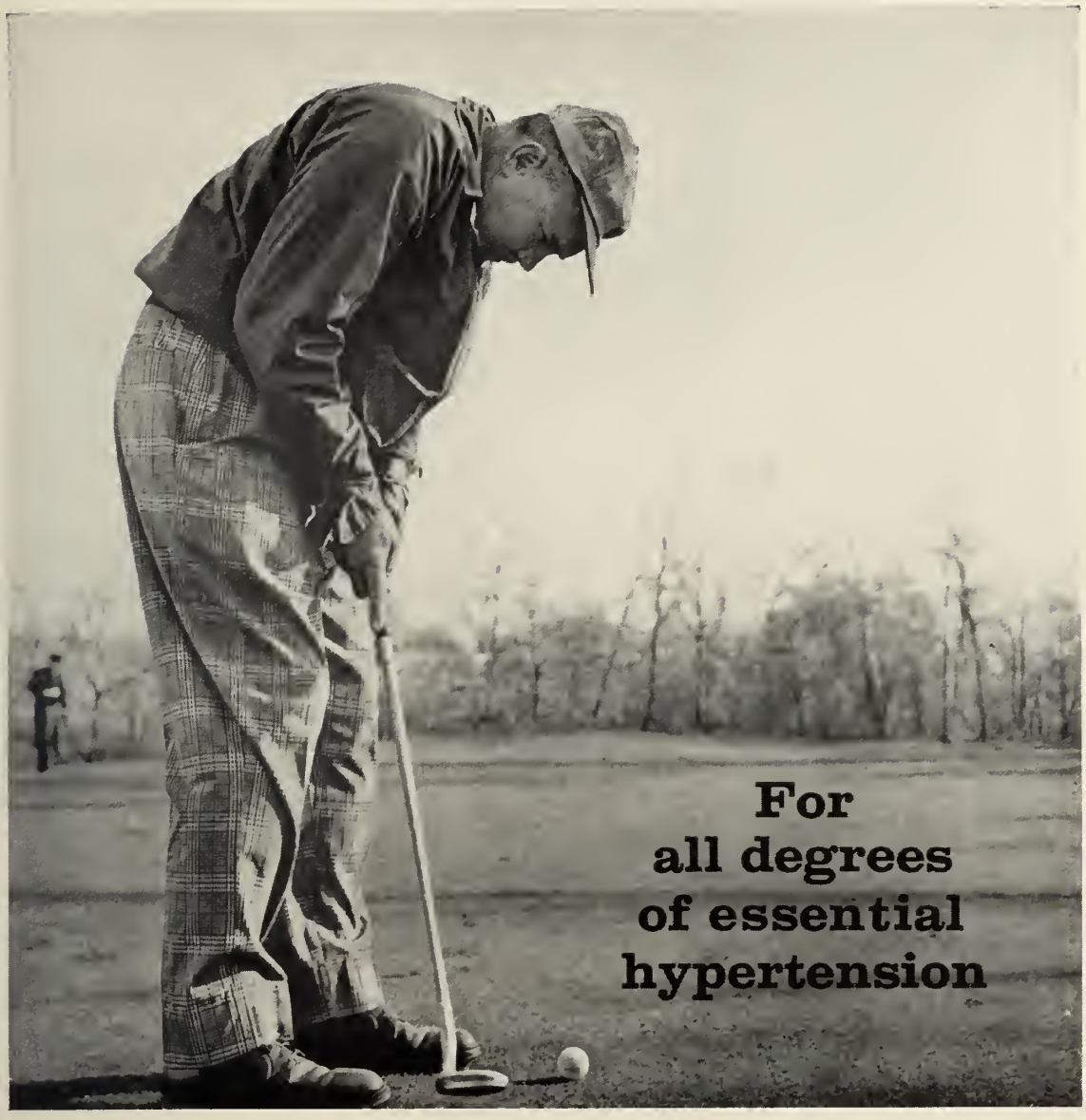
## Fourth District

(COUNCILOR: EDWIN R. MURBACH, M. D., ARCHBOLD)

### LUCAS

The general section of the Academy of Medicine of Toledo and Lucas County heard two speakers discuss health insurance at their March 2 meeting. Dr. Paul I. Robinson, chief medical director of the Metropolitan Life Insurance Co., New York, spoke on "The Doctor and Health Insurance." He was followed by Dr. Charles L. Hudson, Delegate to the American Medical Association and member of the AMA Board of Trustees, Cleveland, who spoke on "Where Do We Go From Here?"

The surgical section met on March 16 and heard Dr. Manuel Lichtenstein, Chicago, speak on "Causes for Poor Results Following Cholestectomy." On March 30, Dr. William Altemeier, director of Surgical




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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

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Service, Cincinnati General Hospital, spoke before the specialities section concerning "Hospital Infections."

## Fifth District

(COUNCILOR: HENRY A. CRAWFORD, M. D., CLEVELAND)

### CUYAHOGA

Dr. John R. Reed, chairman of the education and scientific work committee of the Cleveland Academy presented the findings of physician discussion groups, as compiled and summarized with the cooperation of the executive committee, to the March meeting of the Academy of Medicine of Cleveland. The title of Dr. Reed's presentation was "Health Care and Costs — the Doctors Respond."

Many other specialty meetings were held throughout the month.

## Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

### COLUMBIANA

A recent Ohio law clearing the way for professional people to become incorporated was discussed by State Rep. Warren Bettis and investment representatives at a meeting of the Columbiana County Medical Society.

Bettis along with James Murphy, representative of L. A. Caunter & Co., discussed provisions of the law as it applies to attorneys, physicians, dentists and accountants.

Arrangements for the society's planned mass Sabin polio vaccine immunization program were discussed.

* * *

At a recent meeting of the Columbiana County Medical Society information on the oral polio fact sheet and the mass oral vaccine distribution was presented. The meeting was under the direction of Dr. William A. Kolozsi, Salem. — *The Salem News.*

### MAHONING

Dr. Edward R. Annis, Miami, Fla., member of the AMA Speakers' Bureau, brought to Youngstown to speak at the February 20 meeting of the Mahoning County Medical Society, had a full day before and after the meeting.

At 9:00 a. m., he went to radio station WFMJ with Dr. John J. McDonough, to tape record the program, "Diagnosis," which was broadcast at 8:05 p. m. that evening.

At 10:30, he held a press conference in his hotel room. At lunch, he spoke to the members of the "Freedom Team," the Mahoning County physicians who are prepared to speak at all gatherings on the King-Anderson bill.

At 1:45 p. m., he teletaped a panel program at WKBN-TV, which was televised the following Saturday at 6:00 p. m.

The medical society meeting, which was open to the general public, began with 500 persons for dinner at the Pick-Ohio Hotel. Dr. Annis interrupted his talk at 8:30 p. m. to make a television address which was televised "live" from the dinner, and after the TV portion, continued his speech for the dinner audience.

He had to leave the banquet hall in time to get to WKBN for a 10:30 p. m. radio program, "Consultation," with Dr. Jack Schreiber, at the conclusion of which, he hurried to the television studio of WKBN-TV to appear on the 11:10 news program.

Chairman of the dinner-meeting was Dr. F. A. Resch. Dr. Annis was introduced on the TV portion by Dr. McDonough. Dr. C. W. Stertzbach, president, presided. — Mr. Howard Rempes, Jr., Executive Secretary.

### STARK

Dr. Henry Moulds, associate professor of philosophy at Kent State University, spoke on "How to Think Straight about Communism" at a recent meeting of the Stark County Medical Society. Dr. Moulds is chairman of a new course at Kent which will study communism from the standpoint of current economics, political theory, propaganda, science, and education.— *The Massillon Evening Independent.*

* * *

The Canton Repository's eighth Health Forum was held recently in cooperation with the Stark County Medical Society and the Canton Academy of Medicine. The program was devoted to a panel discussion on "How To Stay Healthy Mentally."

The four speakers were Dr. Marion M. Estes, Dr.


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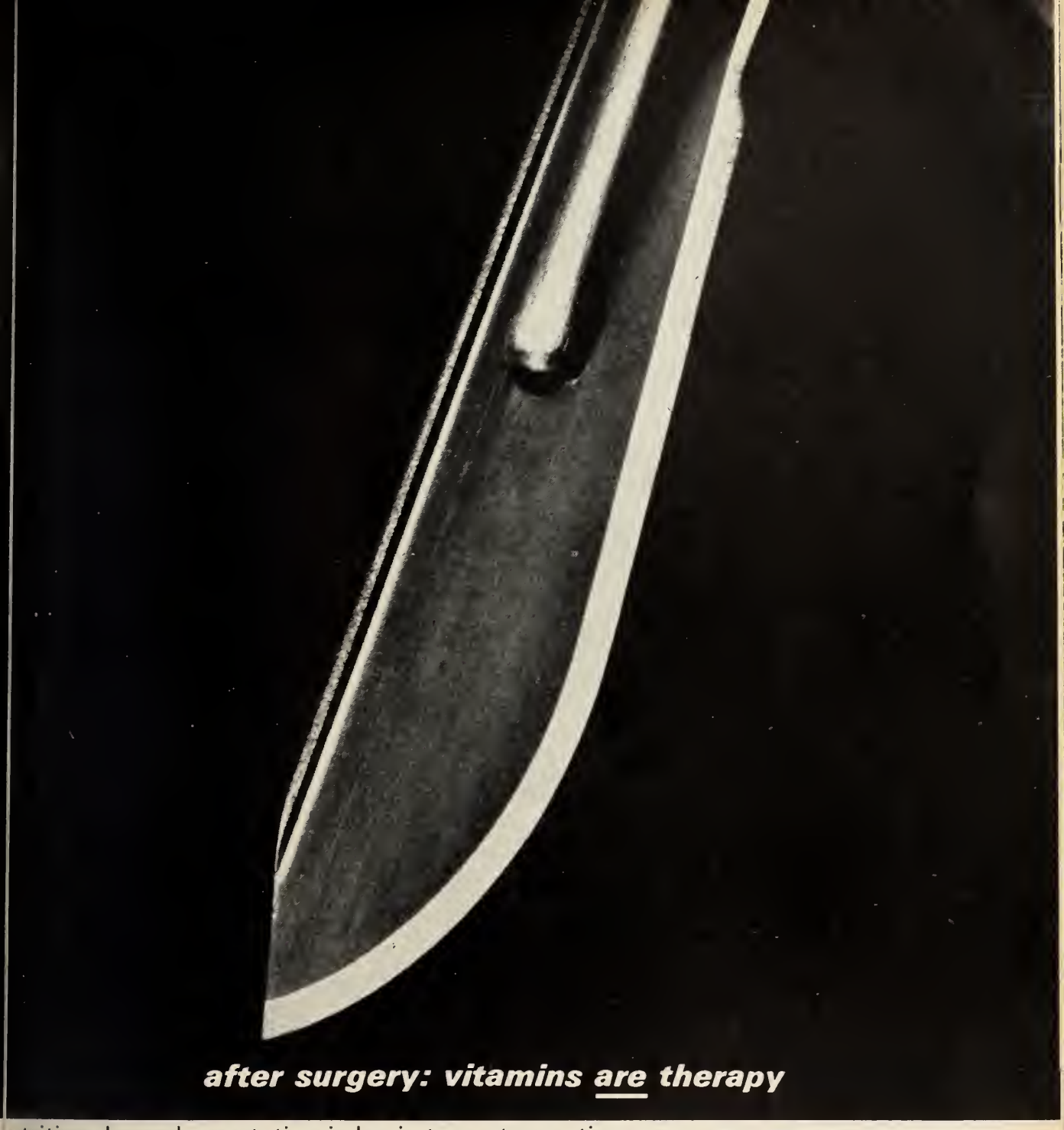
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Francis C. Boyer, Dr. Robert B. Bird and Dr. Harold C. Ziegler. — *The Canton Repository.*

### SUMMIT

Dr. Eldred B. Heisel, Chief of Dermatology at Ohio State University's School of Medicine, spoke at the March meeting of the Summit County Medical Society. Dr. Heisel's topic was "Muco Cutaneous Lesions, Windows To Systemic Disease."

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

### BELMONT

The Belmont County Medical Society met with its auxiliary on March 15. Dr. William E. Hunt, neurosurgeon at University Hospital, Ohio State University, spoke to the group on the subject "Treatment and Care of Head and Neck Injuries."

* * *

Dr. William B. Kiesewetter, head of surgical service at the Pittsburgh Children's Hospital, was the guest speaker at a recent meeting of the Belmont County Medical Society. Dr. Kiesewetter gave an informative talk on "Tip-Offs to Trouble in the Newborn." — *The St. Clairsville Gazette.*

* * *

Dr. C. Merle Welch, Department of Anesthesiology, Ohio State University, spoke to the February meeting of the Belmont County Medical Society on the subject "Respiratory Obstruction As A Problem Of The General Physicians and Surgeons."

## Ninth District

(COUNCILOR: CHESTER H. ALLEN, M. D., PORTSMOUTH)

### JACKSON

Dr. John Cook, Oak Hill, is the new president of the Jackson County Medical Society.

Other officers named at the election meeting were Dr. Gordon Leonard, Jackson, vice-president, and Dr. B. J. Allison, county health commisisoner, secretary-treasurer. Dr. C. C. Fitzpatrick was named delegate to the OSMA state convention and Dr. Leonard alternate. — *The Oak Hill Press.*

### LAWRENCE

Three professional men addressed a recent meeting of the Lawrence County Medical Society.

Dr. Chester H. Allen, Portsmouth, OSMA Ninth District Councilor, spoke of his work in the vocational rehabilitation field.

Attorney Donald Siebring, Columbus, presented an explanation of professional incorporation under the provisions of the recently enacted Senate Bill 550.

Dr. R. D. Kimbrough, health commissioner and member of the local Society, addressed the group on medical services offered by the Public Health Department on the use of instruments to detect measurement of radiation.

### SCIOTO

Dr. James Bennett, Instructor, Department of Plastic Surgery, Ohio State University, spoke before the March meeting of the Scioto County Medical Society on the subject, "Operative Treatment of Cancer of Face, Including Lower Lip."

## Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

### FRANKLIN

"Specialty Society Day" was observed by the Academy of Medicine of Columbus and Franklin County at its March meeting held at the Pick-Fort Hayes Hotel in Columbus.

The meeting was held in cooperation with the Central Ohio Academy of General Practice, the Neuropsychiatric Society of Central Ohio and the Columbus Surgical Society.

Three guest speakers highlighted the program. Dr. Robin Anderson, chief of the department of plastic surgery at the Cleveland Clinic, led off the program with the subject "Plastic Incisions and Closures in General Surgery."

Following Dr. Anderson, Dr. Roy C. Lewis, Cleve-


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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Kelfer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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land, spoke on "The Office Diagnosis and Treatment of the Arrhythmias without the Electrocardiogram." To climax the evening, Dr. James F. Maddux, Deputy Medical Officer in charge of the U. S. Public Health Service Hospital in Lexington, Kentucky, spoke on "Hospital Treatment of Narcotic Addiction."

### KNOX

Dr. David Heydinger, Columbus, discussed the Congo as he saw it two years ago at the annual dinner of the Knox County Medical Society. Dr. Heydinger told of the medical, social, and economical aspects of the Congo at that time and illustrated his remarks with movies. — *Mt. Vernon News.*

* * *

Dr. John R. Claypool, retired Mount Vernon physician, received a "Certificate of Distinction" and gold pin from Dr. Julius Shamansky signifying 50 years' service to the medical profession. The award was made on behalf of the Knox County Medical Society and OSMA.

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

Fifty-four physicians participated in committee meetings held simultaneously prior to the regular February meeting of Lorain County Medical Society. This innovation, planned by Dr. R. E. Hayes to activate all committees, and conserve the doctors' time, received the enthusiastic support of the membership.

The 5:30 committee hour was followed by the usual Social Hour and dinner at Oberlin Inn, when the program was given over to Society business. This will be the pattern for alternate months.

Dr. Herbert B. Rosenbaum gave a Memorial Address for Dr. George M. Blank of Lorain and the membership stood in silent tribute.

Special emphasis was placed on the March meeting when Sociology Professor Raymond Mack of Northwestern University will speak on "The Independent Professional in a Welfare State." Wives of the members are being invited, and also physicians from other counties in the 11th Councilor district. Editors of the county will be guests at dinner, and representatives from a wide variety of interests will be invited to the lecture in the Kettering Science Building of Oberlin College.

Committee reports were given by chairman S. J. Birkbeck, Blood Bank; R. S. Van Dervort, Education; R. A. DeMarco, Liaison with County Welfare; John W. Wherry, Insurance; D. A. Radefeld, Public Relations; and Anthony Piraino, Grievance.

The necessity of writing to Senators and Congressmen regarding the King-Anderson Bill was approved and in addition to the communication from the Medical Society, individual members were urged to write, and encourage their friends and patients, also. Additional support for medicine's viewpoint from other groups and individuals in the county will be sought.

Irwin M. Suna, M. D., anesthesiologist, was unanimously elected to associate membership, and Mary C. Gatewood, M. D., to honorary membership status in the Society.

Eleventh District Councilor Lawrence C. Meredith, M. D., briefly addressed the group.

* * *

Ninety-six members and guests were present for the Lorain County Medical Society dinner at Oberlin Inn on the occasion of their regular meeting March 13.

Following the dinner all convened in the Lecture Hall of the new Kettering Building of Oberlin College. There they were joined by representatives of various professions and interests from all parts of the county who had been invited by the Medical Society to share with them a lecture given by Dr. Raymond W. Mack, head of the Sociology Department of Northwestern University. Dr. Mack spoke on "The Individual Professional and the Welfare State." Following the lecture was a lively and informative discussion period. Dr. Roy E. Hayes pre-




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sided at both the dinner and the lecture, introducing Dr. Mack to the audience.

* * *

An innovation to conserve time of members was introduced at the February meeting of the Lorain County Medical Society. Physicians participated in simultaneous committee meetings before the regular society meeting at the Oberlin Inn.

Dr. Herbert B. Rosenbaum gave a memorial address for Dr. George M. Blank of Lorain. Dr. Irwin M. Suna, anesthesiologist, was elected to associate membership and Dr. Mary C. Gatewood to honorary membership in the society.—*Elyria Chronicle Telegram.*

* * *

### MEDINA

The Medina County Medical Society at the January 1962 meeting decided that the group should sponsor a community-wide Sabin Oral Polio vaccine program. The Public Health Committee, chaired by Dr. Myrl Nafziger of Wadsworth, was made responsible for working out the details of the program. At the February meeting the committee reported that it was felt that school children should be given the Oral Polio vaccine during school hours and that four central locations in the County be used for immunizing adults and pre-schoolers. The use of a large school building in Wadsworth, Medina, Lodi and Brunswick for this purpose was proposed. Details of the program in Wayne County were made known to Society members. The Medical Society unanimously adopted the resolution to proceed with this important Public Health step; Dr. Klotz, Society President, then charged the Public Health Committee with making final arrangements for the program and advised that all Society members would be expected to volunteer to help. Tentative scheduling calls for a late March target date for Type I administration. It is expected that Type II will be given six weeks later.

Lederle Laboratories at Pearl River, New York, have invited the members to visit their plant on October 11 to 13, 1962. Plans are being worked out to make this trip. Wayne County Medical Society is being invited at this same time, we are advised.

Donald Miller, Ed. D., Assistant Professor of Special Education at Kent State University, and Mr. Bruce Bridgeman, Director of the Medina County Training School at Weymouth were the speakers for the January meeting of the Society. The many aspects of the requirements for educating the intellectually retarded child were presented to the physicians of the County. Norman Glazer, M. D., radiologist at Chil-


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dren's Hospital of Akron, was the guest speaker at the February meeting.

Dr. Glazer presented some very interesting slides of x-rays demonstrating some unusual and rare abnormalities of the gastro-intestinal tract. Several important facts concerning incidence of peptic ulceration of the duodenum in children were presented to the Society members. The review was very well received by the group. — Leroy G. Dalheim, M. D., Secretary.

### RICHLAND

The February meeting of the Richland County Medical Society was held in the new dining room of the Mansfield General Hospital on February 15. The resident staff of Mansfield General Hospital, with the guest speakers, were guests of the Society.

At the suggestion of the presiding officer, Dr. Karl Kuehne, the academic portion of the meeting was held first with Dr. James W. Reagan, pathologist and cytologist of the Institute of Pathology, Western Reserve University, and Dr. Roger B. Scott, a gynecological specialist on the faculty of W. R. U. Medical School, being the speakers of the evening. Topic of the evening was "Interpretation and Clinical Application of the Papanicolaou Smear with Special Emphasis on Gynecological Diagnosis." Dr. Reagan first discussed the factors influencing the accuracy of the cytological diagnosis: Repeated emphasis was made of the necessity for team work that must exist between the cytologist and the clinician.

Dr. Scott prefaced his remarks with the mention of the marked reduction in mortality percentage of cervical carcinoma, due chiefly to early cytological detection methods. The techniques of taking good smears and the subsequent biopsy, if indicated, were discussed.

Dr. Karl Kuehne opened the business meeting at which Dr. David Massa was duly elected to the Board of Censors.

Dr. James Ludwig, past-president, played a taped recording of actor Ronald Reagan discussing the proposed King-Anderson bill. The comment was made by Dr. Harry Wain that the recording was reaching the wrong audience. The discussion then centered around the problem as to how to reach more of the right people with our story. It was emphasized that each physician must play a major role in seeing that our views are put across to the public.

Dr. Lawrence Meredith, Eleventh District Councilor, spoke briefly on methods of disseminating information to the general public, and gave other announcements of general interest.

It was moved and seconded that the Richland




County Medical Society send a resolution opposing H. R. 4222 to the members of Congress representing this District, and that copies of this resolution be sent to many organizations in the county, with the hope that they, too, will adopt similar resolutions.

A resolution adopted by the North Central Ohio Pharmaceutical Association in opposition to H. R. 4222 was read to the Society.

Dr. Edward Beilstein spoke briefly on the Richland County Speech and Hearing Center. He mentioned that this was being suported by local funds and that steps are now being taken to advise the public of its existence and purpose. — Dr. Carroll E. Damron, Secretary.

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Public Health Service has authorized a 50 per cent increase, to $38.2 million, for medical stockpile procurement and emergency health training. Also, 750 more mobile hospitals will be bought, totaling 3,432 in operation, a long stride toward the estimated need of 9,500.

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The Ohio Academy of General Practice is now in its new building in Columbus. The address is 4075 N. High Street, Columbus 14, Ohio.

# Coming Meetings . . .

**American Medical Association**, Annual Meeting, Chicago, June 24-28.

**Ohio State Medical Association**, Annual Meeting, Columbus, May 14-18.

**American College of Physicians**, 43rd Annual Session, Philadelphia, April 9-15.

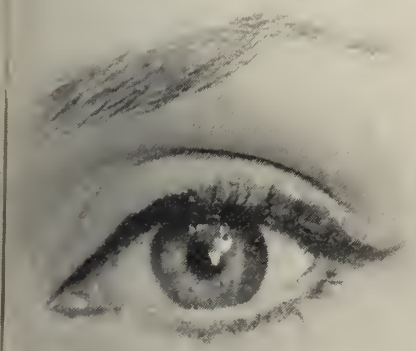
**The George M. Curtis Lecture**, Ohio Union, Ohio State University April 23, 4:00 p. m., by Dr. Francis D. Moore, Moseley Professor of Surgery, Harvard Medical School.

**Ohio State Radiological Society** meeting, Akron, May 25-27, Chapin Hawley, M. D., Secretary, 927 Carew Tower, Cincinnati 2.

**Ohio State Surgical Association**, Annual Meeting, Nationwide Inn, Columbus, Friday, May 11.

**University of Cincinnati College of Medicine**, Annual Samuel Freedman Lecture in Diagnostic Radiology, April 28, 29.

**32nd All-Ohio Safety Congress and Exhibit**, sponsored by the Industrial Commission of Ohio, Deshler Hilton Hotel and Neil House, Columbus, April 17-19.

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## Taft Takes Swipe at H. R. 4222

Robert A. Taft, Jr., Cincinnati, who is a candidate for the office of congressman-at-large, wants no part of the medical care program which is provided for by H. R. 4222.

Speaking in Chicago in support of a candidate for Congress from the 12th Illinois District, Taft said:

"The Medicare Program, as proposed by the Kennedy Administration, would be a foot in the door for establishing control of medical care, not only for those who can show need for assistance, but on a compulsory basis for all American citizens covered by social security who are more than 65, and logically would be required as the next step for all citizens, regardless of age."

## Ohio Society for Crippled Children Names Reiser To Executive Post

Karl P. Reiser, recently of Cleveland, has been named executive director of the Ohio Society for Crippled Children and Adults, Inc., which has its headquarters at 311 Kendall Place, Columbus 5. He succeeds Walter B. Underwood, who retired after many years in that office. Announcement of the appointment was made by A. R. Ritchey, president of the Society.

A native of Toledo, Mr. Reiser received his bachelor's degree from the University of Toledo and later earned a master's degree in vocational guidance from Columbia University. During World War II, he was with the Red Cross in the South Pacific and after the war worked with the Red Cross in the southeastern area of the United States. In 1950 he was assigned to the League of Red Cross Societies in Geneva, Switzerland, to act as field director for Arab relief in Trans Jordan.

For the past eight years he has been on the staff of the Ohio Division of the American Cancer Society with headquarters in Cleveland.

## Diagnostic Radiology

On Saturday and Sunday, April 28 and 29, Dr. John Evans, director of the Department of Radiology, New York Hospital, Cornell Medical Center, will deliver the 12th annual Joseph and Samuel Freedman Lecture in Diagnostic Radiology at the University of Cincinnati College of Medicine. There will be no charge for the lectures.

Radiologists desiring to attend are requested to write Dr. Benjamin Felson, X-ray Department, Cincinnati General Hospital, for further details.

## Program on Epilepsy Scheduled In Columbus, April 28

The Central Ohio Institute on Epilepsy has announced a program sponsored by the Aurora Epilepsy Association in the Seneca Hotel, Columbus, on Saturday, April 28. Registration begins at 9:00 a. m. with the program starting at 9:30.

Opening presentation will be entitled "What Is Epilepsy?" by Dr. Madison Thomas, University of Utah.

Three morning workshops will deal with the following topics (with the chairman of each indicated):

"Diagnosis of Epilepsies," Dr. Max Schnitker, Toledo neurosurgeon.

"Epileptic Child in School," Dr. Thomas.

"Community Responsibility and Rehabilitation," Dr. Frank Risch, The Epi-Hap Program, Los Angeles.

Luncheon at $2.50 per plate will be served, after which the subject, "Employment of the Epileptic," will be presented by Dr. Risch.

Afternoon workshops:

Medical Management of Epilepsy," Dr. Schnitker.

Epileptic Child in Home and Neighborhood," Dr. Thomas.

The Epileptic Employee," Dr. Risch.

Final presentation will be on "Epilepsy and the Law," by Dr. Schnitker.

Outstanding panels of physicians have been announced as participants in the workshop sessions.


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## Cleveland Academy Invites Guests To April 25 Heart Program

The Academy of Medicine of Cleveland has invited physicians from other areas to attend a special program on Heart Disease and Surgery, co-sponsored by the Scientific Council of the Cleveland Area Heart Society. The program beginning at 3:15 p. m. on Wednesday, April 25, will be held in the Academy auditorium, 10525 Carnegie Avenue.

Afternoon panel program chairman is Dr. Harold Feil. Emphasis will be on diagnosis, indications and contraindications for surgery.

Three afternoon panels are as follows, with persons participating indicated:

**Surgery in Congenital Heart Disease:** Dr. Jerome Liebman, moderator; Drs. Earl B. Kay, Frederick S. Cross, George H. A. Clowes, Jr., Donald B. Effler.

**Rheumatic Heart Disease:** Dr. H. K. Hellerstein, moderator; Drs. Jay L. Ankeney, John Kralik, Melvin M. Reydman, and John Storer.

**Arteriosclerotic Heart Disease:** Dr. Arthur D. Nichol, Moderator; Drs. Claude S. Beck, David S. Leighninger and Edward S. Rambousek.

After dinner speaker will be Dr. Charles K. Friedberg, director of cardiology and attending physician, Mt. Sinai Hospital, New York City, and associate clinical professor of medicine, Columbia University.

Reservations for dinner should be sent to the Academy of Medicine of Cleveland, 10525 Carnegie Ave., Cleveland 6, Ohio.

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## Heart Research Grants Given To 17 Persons in Ohio

The American Heart Association, through the state and local Heart Associations, has announced that 17 Ohioans will receive fellowships for research in various phases of heart function and disease, several of whom will receive awards as established investigators.

Heart fund dollars help support the research program of the AHA. Within the past 12 years it has invested more than $65,000,000 in heart research. Grants in Ohio are being made to the following persons:

Cincinnati: Irwin B. Hanenson, George W. Kittinger and Paul Nathan, all of the May Institute for Medical Research of the Jewish Hospital Association.

Western Reserve University School of Medicine, Cleveland: Daniel K. Bloomfield, Robert E. Botti, John W. Corcoran, Berhard R. Landau, Oscar D. Ratnoff, Nick Sperelakis, Anna N. Taylor and Randall H. Travis.

Others in Cleveland: Hilaire De Geest, St. Vincent Charity Hospital; David B. Gordon, Mount Sinai Hospital; Philip W. Hall, III, Cleveland Metropolitan General Hospital; Philip A. Khairallah, Cleveland Clinic; Akio Suzuki, St. Vincent Charity Hospital.

Columbus: Heinz P. Pieper, Ohio State University College of Medicine.


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Surgery of Colon & Rectum, One Week, June 4
General Surgery, One Week, May 7
Gynecology, Office & Operative, Two Weeks, June 11
Vaginal Approach to Pelvic Surgery, One Week, May 14
Obstetrics, General & Surgical, Two Weeks, April 30
Pain Relief in Childbirth, 3 Days, July 11
Proctoscopy & Sigmoidoscopy, One Week, July 16
General Practice Review, One Week, May 21
Advanced Electrocardiography, One Week, June 18
Gallbladder Surgery, 3 Days, June 18
Surgery of Hernia, 3 Days, June 21
Neuromuscular Diseases, Two Weeks, June 11
Hematology, One Week, June 4
Advances in Medicine, One Week, May 7
Blood Vessel Surgery, One Week, May 14
Breast & Thyroid Surgery, One Week, May 21
Fractures & Traumatic Surgery, Two Weeks, June 11
Diagnostic Radiology, Two Weeks, April 23

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**Each Salutensin tablet contains:** 50 mg. Saluron® (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

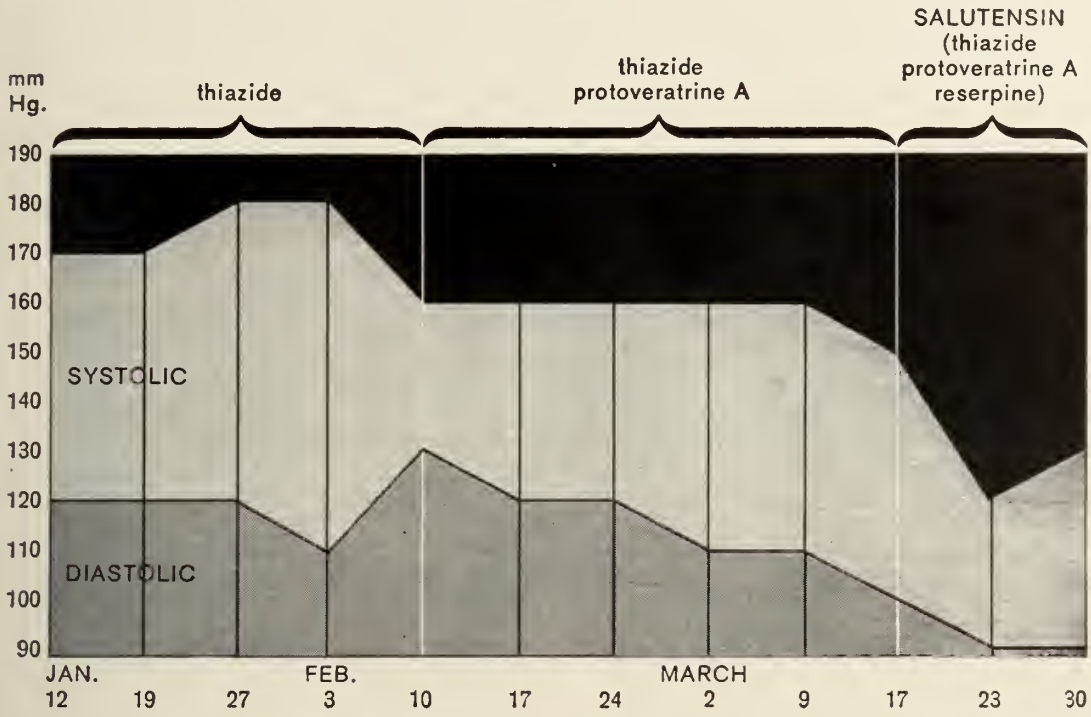
**Supplied:** Bottles of 60 scored tablets.

**References:** 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

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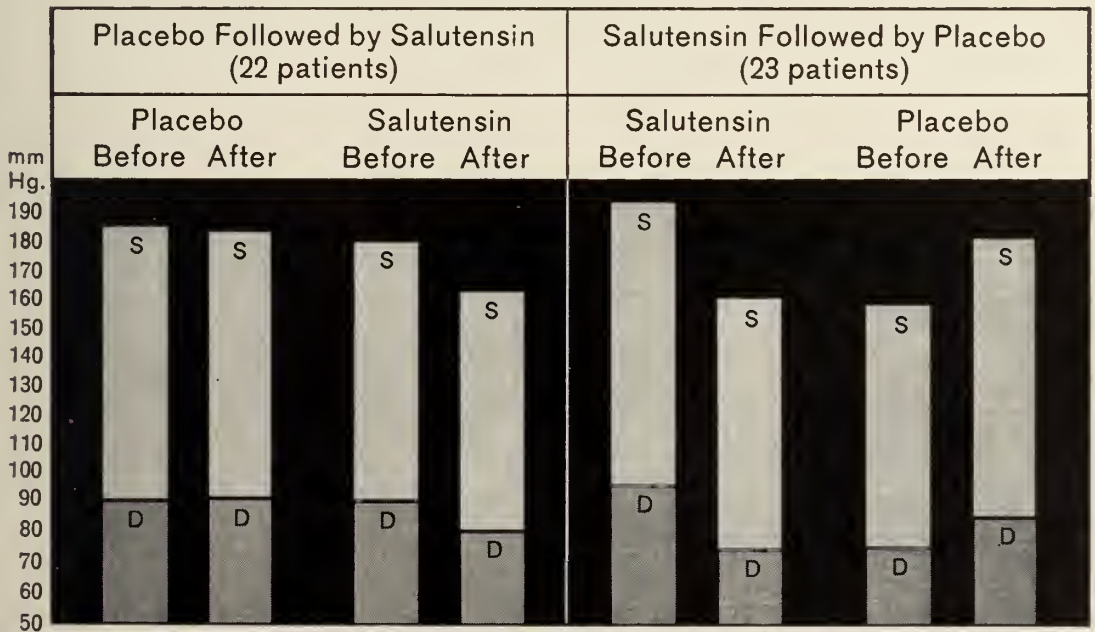
**11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE**

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)




**3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY**

Mean Blood Pressures–Systolic (S) and Diastolic (D)




In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

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Out of the Blue

# Some Claims Must Have Statement Of Physician's Charge Attached

By R. DEAN DOOLEY, M.D.
Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

DURING a visit in the office of our Director of Claims Service, I noticed a huge stack of claim applications. Being inquisitive, I inquired as to the details relating to this surprising situation. I was advised that the bulk of the claims belonged to the 65 year old group which could not be paid because of the lack of physicians' statements for services rendered. Letters had been sent to the subscribers requesting physicians' statements and, in some instances, several letters had been transmitted without response.

I think it is obvious that many of our elder subscribers do not understand the conditions of the contract and are even confused by the letters they receive from us. I saw cases in which three separate claim applications had been submitted and processed. In some cases, obviously, the subscriber had misinterpreted our letter and instead of requesting a bill, asked that the physician submit another claim application, which he dutifully executed.

### Subscriber's Responsibility

Our Claim Department has been unwilling to approach physicians in these instances, knowing that the correspondence load in most physicians' offices is already intolerably heavy. According to the wording of the contract, the responsibility of supplying the statement belongs to the subscriber, rather than the attending physician. It has been our expectation that the subscriber would forward the statement received from the physician along with the claim form and, thus, fulfill the terms of the contract. The size of the pile of unpaid claims unmistakenly testifies that a considerable number of our subscribers, for one reason or another, fail to complete the claim application by excluding the physician's bill.

At the risk of being repetitious, I believe it is timely that I again describe the contracts which require physicians' financial statements for services rendered.

### Major Contract

The development of the Major Contract, with high indemnity schedules, dictated the need of avoiding overpayment to subscribers by the device of requiring physicians' bills. We have had no problems with the Major Contract, because the feature of statement requirements has been adequately publicized and employers have implemented the directive by in-plant instructions. There has been no registered complaint by physicians.

### Special Preferred Contract

The Special Preferred Contract was offered to the 65-and-over group in 1960 and because of the level of indemnification and peculiar status of its subscribers, the clause requiring physicians' statements was inserted. Most subscribers, and many physicians, are not acquainted with the provision requiring statements. This has largely been responsible for the stack of incomplete claims referred to earlier.

### Direct-Pay Contract

Direct-pay subscribers who have converted from the Standard to the Special Preferred Contract must also supply physicians' statements with the claim applications. The direct-pay group consists of individuals who have been members of groups and have left their employment, but continue to carry their insurance on a billed-at-home basis.

A new over-the-counter Non-Group Preferred Contract is now available in most Blue Cross areas, providing the preferred level indemnities, and likewise requires physicians' financial statements to be submitted with the claim application.

Statements must accompany the claim application. If the claim application and the physician's bill are mailed separately, there is a likelihood that, during the course of processing 2,000 claims daily, the two documents might fail to meet, with resulting confusion.

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The Medical Library Association, 919 N. Michigan Ave., Chicago 11, will hold its annual meeting at the Sheraton-Chicago Hotel, Chicago, June 4-8.

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The 1962 Scientific Session of the American Cancer Society will be held at the Biltmore Hotel, New York City, October 22-23.



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| Zinc (as Zinc Betaine Citrate) | 1.25 mg. |
| Magnesium (as Magnesium Betaine Citrate) | 6.0 mg. |
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# Workmen's Compensation . . .

## First of a Series of Articles on the Ohio Program Shows Physicians How To Obtain Prompt Payment

DURING the next several issues *The Journal* will publish articles pertaining to the administration of the Ohio Workmen's Compensation Law, especially rules and procedures on medical matters.

Just about every physician in Ohio has some dealing with the Bureau of Workmen's Compensation during a given year. For that reason he should keep himself informed on Workmen's Compensation matters. It is suggested that the articles in this series be clipped and filed for quick reference.

These articles were prepared with the assistance of James L. Young, administrator of the Bureau, and members of his staff.

This, the first of the series of articles and the second article deal primarily with claim forms and medical fee bills. If a physician follows the suggestions presented, he will help the Bureau to pay both compensation and medical claims promptly.

### Who Is Entitled To Receive Benefit Payments?

For an injured party to have a **right** to benefits under the Workmen's Compensation Law of Ohio, he must have an injury as defined by the Law and, further, his injury or occupational disease must be sustained in the course of and arising out of his employment.

### What Forms Are Used for Claims for Medical Bills Only?

If the claim involves medical bills only, or if the extent of disability is seven days or less lost time from work, the claim should be filed on Form C-3 (pink color) for an injury, or on Form OD-3 if an occupational disease is involved.

### The Attending Physician's First Fee Bill in a Medical Only Claim.

The first fees of the attending physician in a claim for medical bills only should be submitted in the space provided on either the OD-3 or the C-3 application forms.

### Supplemental Fee Bills in Medical Only Claims.

If the treatments for the injury or occupational disease do not terminate within a reasonable time period or if additional space is required, the Form C-19 should be used by the attending physician to file his supplemental fees.

### How Does the Attending Physician Obtain the Various Forms?

Forms C-3 and OD-3 are those to be used for the filing of the initial claim and should be obtained from the injured party's employer. The forms may be obtained from the local district office of the Bureau of Workmen's Compensation if they are unobtainable from the employer.

If Form C-19 is needed by the attending physician, the space indicating the necessity for further treatments on the C-3 or the OD-3 forms should be checked. When the Bureau receives a C-3 or an OD-3 form with this space checked, a Form C-19 containing the claimant's name, the claim number, the employer's name, and the date of the injury is mailed to the attending physician immediately.

### What Does the Attending Physician Do with the Various Forms When the Medical Information Is Completed?

When the attending physician has completed Part II of the C-3 or OD-3 form, the form should be returned to the employer for his completion of Part I and the certification as to its validity.

Fee bills cannot be paid in a claim until the application has been completed in its entirety so it's imperative that the attending physician does not submit the C-3 or OD-3 form directly to the Bu-

### Want A Speaker on Subject of Workmen's Compensation?

**The Bureau of Workmen's Compensation and the Industrial Commission of Ohio will be happy to provide a speaker on Workmen's Compensation, with special emphasis on fee bills, claims procedure and related subjects. Requests should be directed to: Mr. George H. Thompson, Chief Deputy Administrator, Claims Section, Bureau of Workmen's Compensation, Columbus 15, Ohio.**

### Ohio Physicians' Golf Tournament Scheduled in Akron, June 7

The annual tournament of the Ohio Medical Golfers Association has been announced for the Firestone Country Club, Akron, on Thursday, June 7. The club is the site of the American Golf Classic.

Members of this organization or other physicians interested are invited to send entries to Mr. Robert Elwell, in care of the Toledo Academy of Medicine, 3101 Collingwood Blvd., Toledo 10. A fee of $25.00 includes lunch, steak dinner, prizes, green fees, etc.

reau without the employer's completion and certification of the form.

The Form C-19 may be mailed directly to the local Bureau Office upon its completion by the attending physician since this form involves medical information only.

**How To File Fee Bills in Lost Time Claims.**

If more than seven days of lost time work is involved, the attending physician should submit his first fee bill on a Form C-1A (green color).

**How Does the Attending Physician Obtain a Form C-1A?**

The form C-1A is mailed to the attending physician by the Bureau following receipt of the initial claim application (C-1 or OD-4) from the employer. The form C-1A received by the attending physician will contain the claimant's name, the claim number, the employer's name, and the date of the injury.

**What Does the Attending Physician Do With the Completed C-1A?**

When the attending physician has completed the Form C-1A in its entirety, the form may be mailed directly to the local district office of the Bureau.

**Supplemental Fees in Lost Time Claims.**

Any supplemental fees in lost time claims should be filed on a Form C-19. This form may be obtained by checking the appropriate space on the initial fee bill, Form C-1A, indicating additional treatments are necessary. The Form C-19 will be mailed to the attending physician as is done in claims for medical bills only.

(Watch for Article No. 2 in this Series.)

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"Outpatient Population of Psychiatric Clinics, Maryland, 1958-59," is the title of Public Health Monograph 65. Single copies of the publication are available on request from the Public Inquiries Branch, U. S. Public Health Service, Washington 25, D. C.





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# Activities of Woman's Auxiliary...

CHAIRMAN, PUBLICITY COMMITTEE — Mrs. F. M. Wadsworth, 35 Pinecrest, Mansfield, Ohio.
(Roster of Officers, Page 519)

### ALLEN

Forty-two members attended a luncheon at the Holiday Inn Motel in February. Hostesses committee: Mrs. J. W. Burke, chairman; Mrs. W. E. Murray, Jr., Mrs. Bernard Glass, Mrs. R. R. Snowball, and Mrs. C. E. Kelley.

Election of officers for next year: President, Mrs. R. L. Wiessinger; president-elect, Mrs. J. D. Albertson; vice-president, Mrs. T. R. Leech; and secretary, Mrs. David A. Barr.

### FAIRFIELD

The home of Mrs. Hubert Amstutz, decorated in the Valentine theme, was the setting for the February meeting of the Woman's Auxiliary to the Fairfield County Medical Society.

Following luncheon, Mrs. Jack Kraker, president, conducted the business session. It was resolved to send a letter to Congressman Moeller stating the view point of the Auxiliary in regard to the Anderson-Kerr Bill.

Mrs. Stanley Sneeringer, chairman of Community Service, gave a report and distributed booklets which she had received from Washington. They contain brief articles on parental selectivity of television fare, and are to be placed in offices where they can be read by the public.

During the social hour, each member present, gave a two minute talk on the subject "This I Find Interesting." A variety of interests were uncovered, ranging through the alphabet from antiques to youngsters.

Mrs. Amstutz was assisted by Mrs. George LeSar, Mrs. Kenneth Taylor, Mrs. Robert Whetstone and Mrs. Stanley Sneeringer, in arranging this informative meeting.

### HAMILTON

Max Rudolf, director of the Cincinnati Symphony Orchestra, was the featured speaker at the February 20 luncheon meeting at the Restaurant Continental of the Hotel Netherland Hilton. His topic was "How Do We Arrive at an Opinion about Music?" Program chairman for the day was Mrs. Maurice Marsh, who had Mrs. Robert Kemper as her assistant. Mrs. Joseph Wilson was chairman of Hospitality; Mrs. John C. Willke planned the decorations, and Mrs. W. Donald Heuer designed the musical note name tags. Mrs. Carl F. Schilling presided.

The Philanthropy Chairman, Mrs. Charles Hoyt, recommended and received passage of a motion providing money for a three-year scholarship for an entering sophomore in a 4-year college accredited nursing school. Provisions to be met included: a resident of Cincinnati who had maintained a C+ average; recommendation by the Director of Nursing, with preference being given to former Health Careers Club members.

The 12th Street Prenatal Clinic of the City Health Department is being staffed by volunteer Auxiliary members on Mondays and Fridays.

Mrs. Calvin Warner, First Vice-President of the State Auxiliary, was chairman of the Special Projects Committee for Heart Fund Sunday. She directed more than 25 social and civic organizations which had volunteered to collect contributions in special areas for which the Heart Association had not been able to secure workers. Auxiliary members served as chairmen, captains, and door-to-door solicitors under her direction.

The newly-organized Speakers' Panel of the Auxiliary came of age in February with a Workshop on Politics and Government, designed to promote political effectiveness through an informed nucleus of Auxiliary members. Its first meeting on February 6 was opened by Mrs. George D. J. Griffin's discussion of "How To Be a Sharp Blade in the Grass Roots." "Rising Costs and Other Allied Problems in Medical Care" was presented by Speakers Panel members, Mrs. Richard Vilter, Mrs. Robert Heidt, and Mrs. Griffin. This consisted of an analysis of hospital costs, drug costs, drug research, increasing number of aged persons and private insurance plans.

At the second session on February 13, Mrs. Griffin spoke on the Kerr-Mills Law. Mrs. Warren Richards, Auxiliary member, social worker, and board member of the Cincinnati League of Women Voters, spoke on existing plans in various states for care of the medically indigent aged. Mrs. George Moyer, past-president of the Cincinnati League of Women Voters and board member of the Ohio State League of Women Voters, discussed "The Ohio Legislature and How It Works." Mr. Fred Beyer, director of the Hamilton County Welfare Department, explained care for the medically indigent aged in Hamilton County.

"The Washington Viewpoint on Medical Care of the Aged" was presented by Dr. D. J. Griffin at the meeting of the Workshop on February 28. This was

*(Continued on Page 512)*



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**References:** 1. Carpenter, E. B.: South. M. J. 51:627, 1958. 2. Hudgins, A. P.: Clin. Med. 8:243, 1961. 3. Lamphier, T. A.: J. Abdomin. Surg. 3:55, 1961. 4. Levine, I. M.: Med. Clin. N. America 45:1017, 1961. 5. Meyers, G. B., and Urbach, J. R.: Penna. M. J. 64:876, 1961. 6. Perchuk, E., Weinreb, M., and Aksu, A.: Angiology 12:102, 1961. 7. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 8. Schaubel, H. J.: Orthopedics 1:274, 1959. 9. Steigmann, F.: Am. J. Nursing 61:49, 1961.

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followed by a discussion covering methods of political effectiveness in Hamilton County.

The Workshop was scheduled to be climaxed by a joint dinner meeting with the Academy of Medicine on March 8.

### HURON

Mrs. John Gardiner presented an informative program titled "Civil Defense — Latest Developments" at the February meeting of the Woman's Auxiliary to the Huron County Medical Society. Home preparedness and subsequent survival of the family was stressed.

The home of Mrs. William Graham in Wakeman was attractively appointed for the dessert meeting.

### MONTGOMERY

The following is a brief outline of the activities of the Montgomery County Auxiliary for 1962.

January: Theme "Friends and Neighbors" have a special place in my life. The door of my home swings wide open. Mental Health Discussions.

February: Special Guest Day Luncheon and Fashion Show.

March: Tour of Dayton Art Institute.

April: Meeting with Dental and Pharmaceutical Auxiliaries.

May: Installation of Officers. Nurses Scholarships awarded.

The AMEF sale of Christmas cards was a smash hit on the Auxiliary scene. Final tabulations give an admirable amount of $1183.00, to be sent to AMEF.

The Award of Merit meeting (November) was chosen by Mrs. Lester Sontag, State President, as the outstanding Community service program in the State.

### SCIOTO

Mrs. Jack MacDonald is serving as president of the Woman's Auxiliary of Scioto County Medical Society in the coming year. Election of the 1962-63 officers was held at the February meeting in the home of Mrs. Jerome Rini.

Others elected to serve with Mrs. MacDonald are Mrs. Spencer W. Miller, vice-president; Mrs. Rini, president-elect; Mrs. L. B. Hatch, secretary; Mrs. B. U. Howland, treasurer; Mrs. Robert N. Counts, historian, and Mrs. Chester H. Allen and Mrs. Louis R. Chaboudy, advisory board members.

Mrs. Chaboudy, the current president, conducted the business session.

The afternoon auxiliary meeting was held in the form of a tea. Mrs. Milton H. Levine presided at the urn.

Guests attending were Mrs. Thekle Albanese, Dr. Ruth B. Bennett, Dr. Marie B. Rogowski and Mrs. Vincent Pentiuk.

Guest speaker for the afternoon was Fred Jaeger Jr. of Columbus, whose subject was "Understanding Estate Planning."

Mr. Jaeger explained why husbands and wives should plan their estates together. Mr. Jaeger also discussed various trusts.

On the hostess committee assisting Mrs. Rini were Mrs. Levine, Mrs. Howland, Mrs. Clyde O. Hurst and Mrs. Hatch.

### STARK

The Stark County Medical Auxiliary enjoyed the annual Christmas tea on December 19 at the home of Mrs. Raymond Rosedale. Mrs. M. B. Holmes gave a reading entitled "A Christmas Story." Toys, brought by each member, were donated to the Visiting Nurse Society for distribution to needy children. Mrs. Paul Smith was chairman and Mrs. J. J. Brumbaugh was co-chairman.

An interpretive reading of "Auntie Mame" was presented by members of the local Theatre Guild at the January Luncheon at the Canton Woman's Club. Mrs. James C. Hays served as chairman with Mrs. Joseph Yut as co-chairman.

The February 20 meeting was a dessert at the Canton Garden Center. Part of the program was devoted to honoring the women who have served as sponsors to the Para-Medical Careers Clubs in Stark County. Marlington High School in Alliance was approved by the Board as the 12th club to be organized and sponsored by the Auxiliary. Mrs. David Leavenworth is Health Career Chairman. Mrs. Glenn C. Dowell Sr. and Mrs. Jack L. Yahraus served as chairman and co-chairman, respectfully.

### SUMMIT

The Woman's Auxiliary to the Summit County Medical Society held luncheon meeting at Jacomini's Restaurant, March 6. Speaker for the afternoon was Tom Field, veteran newscaster from Station WEWS TV in Cleveland. He spoke about his work, travels and especially his most recent trip around the world.

### VAN WERT

To review this season's programs, the Van Wert Medical Auxiliary held dinner meetings in October, November, December, February, March, and April with an average attendance of 11. Mrs. Walter C. Scheidt, president of the local auxiliary, presided at the meetings, which were planned to correspond with local medical meetings.

The program committee was composed of Mrs. Ralph Rasor, Mrs. Harold Smith, Mrs. Floyd McCammon, Mrs. Donald Walters, and Mrs. Walter Scheidt. Programs included one on "Civil Defense and Community Service" by Mr. Kenneth Kunze, Van Wert County Civil Defense Chairman. With dental wives as guests in November, the program included pictures and narration of a fishing and hunting trip to Alaska by Dr. Harold Lauer and Mr. Lyman Strong, Lima, Ohio. A Christmas exchange

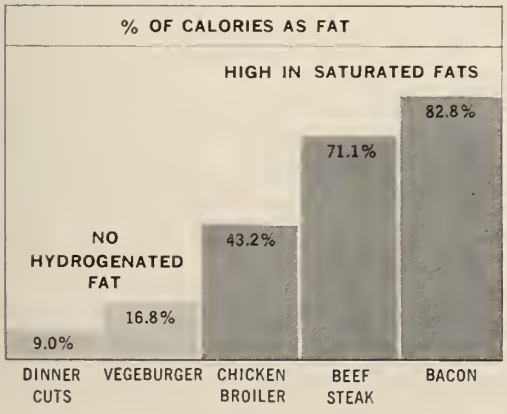
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party was held with a freewill offering for a food basket for a needy Van Wert family. *Doctor Schweitzer of Lambarene* was reviewed by Mrs. Robert Stripe in February. At this meeting, Mrs. Thomas Darnall, Third District director, Findlay, was honor guest. She spoke on current medical legislation and the AMEF. Some senior citizens were also included as guests.

A social and business meeting was held in March. Mrs. H. D. Underwood, legislative chairman, stressed legislation. Reports from various committee chairmen were presented.

The Auxiliary has 14 paid members. It contributed $50.00 to AMEF. The group is sending unused medical books to the Christian Medical Society, Chicago, Illinois. Members distributed Health Career guidebooks and pamphlets to high schools and junior highs throughout the county.

Health Careers Chairman, Mrs. Norman Marxen, spent Career's Day in local High School and Junior High consulting with students who were interested in medical fields. She showed films on nursing, medical technology, physical therapy, dietetics, and other health vocations.

Mrs. Wayne Ayres, Baby Auxiliary chairman, has continued the project at the local hospital and the Auxiliary is adding an otoscope, Boston rocking chair, and a minor surgery light for the nursery.

Several members who belong to Hospital Twigs work at the Hospital Thrift Shop and help with Red Cross Bloodmobile. When needed, members assist the Van Wert County United Health Foundation, Inc. in its program of financial assistance to those in need, health education, and medical research.

In an outreach into the life of the community, members have worked in AAUW, YWCA, Salvation Army, Starr Auxiliary to help needy boys, and church societies.

## College of Chest Physicians Announces Courses

The American College of Chest Physicians has planned five postgraduate courses during 1962 as listed below:

Cardiopulmonary Problems in Children, Chicago, July 23 - 27, Edgewater Beach Hotel.

Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Philadelphia, September 17 - 21, Warwick Hotel.

Clinical Cardiopulmonary Physiology, Chicago, October 22 - 26, Knickerbocker Hotel.

Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, New York, November 12 - 16, Barbizon-Plaza Hotel.

Occupational Diseases of the Heart and Lungs, Detroit, December 3 - 7, Statler-Hilton Hotel.

Additional information may be obtained by writing American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Ill.

Health insurance benefit payments by all insuring organizations averaged an estimated $17.3 million a day during 1961, the Health Insurance Institute reports.


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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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3. **Manuscripts.** Manuscripts should be submitted in the original on standard 8½"x11" white typing paper. The entire text, including case reports and lists of references, should be typed double or triple space with margins of at least one inch on all sides. A copy of the manuscript should be retained by the Author.

4. **Tables and Charts.** Tables and charts that can be set in type may be included, and there will be no charge for their reproduction.

5. **Illustrations.** Illustrations requiring engraving (photographs, drawings, graphs, etc.) will be submitted to an engraver for an estimate of cost. *The Journal* will assume $25 of this expense and the Author will be billed directly by the engraver for the remainder.

Each illustration should bear the figure number and the author's name on the back. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints. Legends for the figures should be written on separate paper.

Used photographs and drawings will be returned after the article is published, if requested within 30 days after publication. Plates will be sent to the Author after the article has been published.

Obtaining permission for the taking and publishing of photographs is the responsibility of the author.

6. **References.** To conserve space and expense, lists of references should be limited to those essential to the subject and to which actual reference is made in the text.

References should be listed in the order of their appearance in the text.

Each reference should include, in this order: Author's last name and initials, title of the article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, month (day of month, if weekly), and year, e.g.

"2. Doe, J. Q., and Roe, R. X.: How to Go About It, Ohio State M. J., 13:24-30 (Feb.) 1920."

Authenticity and accuracy of references are the responsibilities of the Author.

7. **Identification of Patients.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

8. **Reprints.** An order blank for reprints with a table covering cost will be sent with the galley proof to the senior author.

Requests for reprints should be addressed to the Author.

9. **Editorial Assistance.** *The Journal* Staff is anxious to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as "Medical Writing — the Technique and the Art," by Morris Fishbein, M. D., Blakiston Division, McGraw-Hill Book Company, Inc., 330 West 42nd Street, New York 36, New York.

# County Societies' Officers and Meeting Dates

### FIRST DISTRICT

ADAMS—Hazel L. Sproull, President, West Union; Kenneth C. Jee, Secretary, Winchester. 3rd Thursday, January, April, July and October.

BROWN—Charles W. Hannah, President, Sardinia Medical Clinic, Sardinia; Carl A. Liebig, Secretary, Box 245A, R.R. 1, Georgetown.

BUTLER—James L. Sawyer, President, 2650 Stevens Ave., Medical Arts Bldg., Middletown; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. Last Wednesday of alternate months.

CLERMONT—Phillips F. Greene, President, Box 509, Rt. 1, New Richmond; Richard K. Lancaster, Secretary, 684 Batavia Pike-Vermona Drive, Cincinnati 45. 3rd Wednesday, monthly.

CLINTON—Foster J. Boyd, Jr., President, 291 N. South St., Wilmington; Emily B. Buchanan, Secretary, 255 Prairie Ave., Wilmington. 1st Tuesday, monthly.

HAMILTON—Edward Woliver, President, 2605 Burnet Ave., Cincinnati 19; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 2. 3rd Tuesday, monthly, September through May.

HIGHLAND—J. Martin Byers, President, 628 Jefferson St., Greenfield; David S. Ayres, Secretary, 1440 N. High St., Hillsboro. 1st Wednesday, every other month.

WARREN—Ray E. Simendinger, President, 21 E. Main St., Lebanon; D. Paul Ward, Secretary, Box 18, Pleasant Plain. 2nd Tuesday, monthly.

### SECOND DISTRICT

CHAMPAIGN—Victor R. Frederick, President, 848 Scioto St., Urbana; Myron J. Towle, Secretary, 848 Scioto St., Urbana. 2nd Wednesday, monthly.

CLARK—George A. Smith, President, 908 N. Fountain Ave., Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, 35 S. Spring St., Springfield. 3rd Monday, monthly.

DARKE—James H. Dickey, President, 215 E. Fourth St., Greenville; Charles E. Gariety, Secretary, 300 East Third St., Greenville. 3rd Tuesday, monthly.

GREENE—Alvin B. Salisbury, Jr., President, 11 E. Xenia Drive, Fairborn; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly except July and August.

MIAMI—Dale A. Hudson, President, 221 Orr-Flesh Bldg., Piqua; Jack P. Steinhilber, Secretary, 513 W. High St., Piqua. 1st Tuesday, monthly.

MONTGOMERY—Lynne E. Baker, President, 530 Fidelity Bldg., Dayton 2; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Bldg., Dayton 2. 1st Friday, monthly.

PREBLE—Michael O. Phillips, President, 228 N. Barron St., Eaton; Willard Clark, Jr., Secretary, 228 N. Barron St., Eaton.

SHELBY—Ned A. Smith, President, 739 Spruce Ave., Sidney; William F. Mentges, Secretary, 627 N. West Ave., Sidney. 2nd Tuesday, monthly.

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CRAWFORD—L. James Barth, President, West Main St., New Washington; Daniel P. Kenny, Secretary, Tiffin St., New Washington. 3rd Thursday, monthly.

HANCOCK—Benjamin H. Saunders, Jr., President, 1900 S. Main St., Findlay; Thomas W. Darnall, Secretary, 1809 S. Main St., Findlay. 3rd Tuesday, monthly.

HARDIN—Jack C. Lindsey, President, 214 N. Main St., Kenton; Robert B. Elliott, Secretary, 302 N. Main St., Ada. 2nd Tuesday, monthly.

LOGAN—F. Blair Webster, President, 130 N. Main St., Bellefontaine; Douglas W. Beach, Secretary, 1008 N. Main St., Bellefontaine. 1st Friday, monthly.

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MERCER—Donald J. Schwieterman, President, Maria Stein; Robert W. Albers, Secretary, 301 North Cedar St., Coldwater. 3rd Thursday, monthly.

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VAN WERT—Edward E. White, President, 704 E. Central Ave., Van Wert; Thomas R. Wilson, Secretary, Van Wert Co. Hospital, Van Wert. 1st Friday, monthly.

WYANDOT—John M. Thompson, President, 216 N. Sandusky Ave., Upper Sandusky; Donald P. Smith, Secretary, Sycamore. 2nd Tuesday, monthly.

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GEAUGA—Kayoshi Masuoka, President, Medical Center, Chardon Plaza, Chardon; Raymond I. Smith, Secretary, P.O. Box 208, Chardon. 2nd Friday, monthly.

LAKE—Maxwell E. Burnham, President, 358 Bank St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor. 2nd Wednesday, monthly, of January, March, May, September and November.

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HARRISON—James Z. Scott, President, Main St., Box 512, Scio; George E. Henderson, Secretary, Main St., New Athens. Meetings held every three months.

JEFFERSON—Earl Rosenblum, President, 224 N. 4th St., Steubenville; Paul W. Ruksha, Secretary, 633 Lawson Ave., Steubenville. 2nd Tuesday, monthly.

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LICKING—Lawrence H. Miller, President, 205 S. Prospect St., Granville; James A. Quinn, Jr., Secretary, Newark Hospital, Newark. Last Tuesday, monthly.

## County Societies' Officers and Meeting Dates (Continued)

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MUSKINGUM—Rankin A. Nebinger, President, Third St., Roseville; Benjamin W. Gilliotte, Secretary, 821 Market St., Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, 510 West St., Caldwell; Edward G. Ditch, Secretary, 415 Main St., Caldwell. 1st Tuesday, monthly

PERRY—Sydney N. Lord, President, E. Main St., Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—Clarence E. Ash, President, Marietta Memorial Hospital, Marietta; Tuathal P. O'Maille, Secretary, Marietta Memorial Hospital, Marietta. 2nd Wednesday, monthly.

### NINTH DISTRICT

GALLIA—Norman W. Pinschmidt, President, The Gallipolis Clinic, Gallipolis; Thomas P. Price, Jr., Secretary, The Holzer Clinic, Gallipolis. Last Thursday, monthly.

HOCKING—John W. Doering, President, 42 N. Spring St., Logan; Howard M. Boocks, Secretary, Court House, Logan. Called meetings.

JACKSON—John M. Cook, President, Oak Hill Hospital, Oak Hill; Brinton J. Allison, Secretary, Court House, Jackson. Called meetings.

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MEIGS—Joseph J. Davis, President, 306 N. 2nd St., Middleport; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy. Called meetings.

PIKE—Robert M. Andre, President, Lake White, Rt. 2, Waverly; Kenneth Wilkinson, Secretary, 330 E. Main St., Waverly. 1st Tuesday, monthly.

SCIOTO—Spencer W. Miller, President, 1021 9th St., Portsmouth; William E. Daehler, Secretary, 1004 24th St., Portsmouth. 2nd Monday, monthly.

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FRANKLIN—Richard L. Fulton, President, 1211 Dublin Rd., Columbus 12; Mr. William Webb, Jr., Executive Secretary, 79 E. State St., Columbus 15. 3rd Monday, monthly, except May, June, July and August.

KNOX—Delbert C. Schmidt, President, 205 East Chestnut St., Mt. Vernon; Richard L. Smythe, Secretary, Medical Arts Bldg., Mt. Vernon. Usually 1st Wednesday, monthly.

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ROSS—Robert E. Swank, President, 172 E. Main St., Chillicothe; David McKell, Secretary, 60 Central Center, Chillicothe. 1st Thursday, monthly, except June, July and August.

UNION—Walter R. Burt, President, West State St., Milford Center; May B. Zaugg, Secretary, 130 N. Maple St., Marysville.

### ELEVENTH DISTRICT

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ERIE—Carl R. Swanbeck, President, 1218 Cleveland Rd., Sandusky; Donald B. Cuthbertson, Secretary, 421 Wayne St., Sandusky. Alternately, 3rd Tuesday and Thursday, monthly.

HOLMES—Neven P. Stauffer, President, W. Adams St., Millersburg; Luther W. High, Secretary, 109 S. Clay St., Millersburg. 2nd Wednesday, monthly.

HURON—John V. Emery, President, Box 269, Willard; Nino M. Camardese, Secretary, 12 Benedict Ave., Norwalk. 2nd Wednesday, every other month.

LORAIN—Roy E. Hayes, President, Elyria Medical Arts Bldg., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 214 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Nevin J. M. Klotz, President, 162 Main St., Wadsworth; Leroy G. Dalheim, Secretary, 220 East Liberty St., Medina. 3rd Thursday, monthly, except July and August.

RICHLAND—C. Karl Kuehne, President, 480 Glessner Ave., Mansfield; Carroll E. Damron, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—G. G. Stitzinger, President, 1800 Beall Ave., Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday, monthly.

## The Woman's Auxiliary to the Ohio State Medical Association

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2. Mrs. James Wychgel
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3. Mrs. Rivington Fisher
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*Recording-Secretary:* Mrs. Herbert Warm
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# Classified Advertisements

Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

**Physicians seeking locations in Ohio** are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

EXCELLENT OPPORTUNITY for anyone interested in General Practice in pleasant community of 1,000 population (40 miles northwest of Dayton); house-office combination with equipment; no other doctor in town; reasonable price. Available immediately. Box 199, c/o Ohio State Medical Journal.

OFFICE SPACE FOR RENT due to death of physician. Established practice for 40 years. Ten miles to Dayton or Middletown hospitals. Community 3000 population. Will rent or lease office completely furnished with all equipment. Patients records also available. Box 236, c/o Ohio State Medical Journal.

WANTED: General surgeon, Board certified or qualified, to join three man general practice group in northern Minnesota. Excellent hunting, fishing, and skiing in the area. Associated with large specialty group in nearby community. Very active practice with some industrial medicine. New hospital facility completed 1960. Unusually liberal partnership agreement. Contact Mr. Allen G. Farley, East Range Clinic, Virginia, Minnesota.

EXCELLENT COLUMBUS OPPORTUNITY: Location at 2675 W. Broad St., at present occupied by internist for 7 years; previously by general practitioner for 30 years; all private offices, private consultation room, business office, x-ray and three treatment rooms, plus large reception room. Excellent corner location. BR. 9-9401; after 6 p. m., BR. 9-2349.

PHYSICIAN WANTED To take over on rental basis a fully equipped recently deceased doctor's office in southwest Ohio community of 100,000. Records available. $125.00 per month, complete. Call Cincinnati PL 1-4392.

WANTED: Internist, Board eligible or Board certified to join 15 man Ohio Clinic. Excellent opportunity. New facilities. Fine hospitals. Near University. Good library and research facilities. Salary open. Box 257, c/o Ohio State Medical Journal.

COLORED OBSTETRICIAN or PEDIATRICIAN, Cin'ti, Ohio: Excellent opportunity in new medical center; No capital investment required; owner will remodel to suit; wood paneled waiting room, private office, receptionist area and examining rooms. Building also houses Medical Doctor, Medical Laboratory and Dentist Suites. June graduates invited to investigate. Wm. G. Menke, 2532 Indian Mound Ave., Cin'ti 12, Ohio.

WANTED: Excellent opportunity for general practitioner with or without surgical-orthopedic training for association in established industrial clinic in Northeastern Ohio. Guaranteed salary with percentage bonus. Partnership considered. Write stating qualifications. Box 256, c/o Ohio State Medical Journal.

ORTHOPEDIC SURGEON, Board Qualified; 33 years; interested in group practice or association in Ohio. Box 251, c/o Ohio State Medical Journal.

WANTED: Young ob-gyn. specialist, certified or qualified, to join two-man ob-gyn. partnership. Northern Ohio. Excellent office and hospital facilities. Box 264, c/o Ohio State Medical Journal.

WELL-ESTABLISHED GENERAL AND INDUSTRIAL PRACTICE in suburban Cincinnati. Leaving practice in six months. Equipment, records, and office building available. Will introduce Reply to Box 261, c/o Ohio State Medical Journal.

RESIDENT PHYSICIAN: Opening July 1, 1962 in a new 77 bed tuberculosis hospital operated by the State. State Civil Service benefits include paid vacations, holidays, sick leave, retirement plan, 40-hour week. Beginning salary $10,320 yearly. Two bedroom furnished apartment is available on the hospital grounds for nominal charge. License or eligibility in Ohio is required. Southeast Ohio Tuberculosis Hospital, Box 359, Nelsonville, Ohio.

PHYSICIAN to take over well-established practice in prosperous west-central Ohio community; modern office, equipment, furniture, instruments, files, etc., ready for physician to move in and start practice; GP needed in community; local hospital now expanding; rent, lease or buy on terms. Box 262, c/o Ohio State Medical Journal.

LUCRATIVE Small town general practice in suburban Cincinnati for sale, lease, or one year locum tenens. Leaving June 1, 1962, for postgraduate study. Box 242, c/o Ohio State Medical Journal.

FOR SALE—Combination Doctor's office and apartment building, ideally located in Chillicothe, Ohio. Well constructed, completely modern, good condition. First floor consists of 9 well designed and equipped rooms. Has been occupied for a number of years by two General Practitioners who had one of the largest practices in this area. One Doctor is now retired and the other deceased, so the estate is offering the property for sale. Plenty of parking in rear of building. Front and rear entrances. There are 4 attractive apartments on the second and third floors, producing good income. This is a fine investment and a splendid opportunity to establish practice in this community. Reply: C. C. Evans, Jr., 30½ W. Second Street, Chillicothe, Ohio.

PICKER X-RAY - FLUOROSCOPE: Tilt table; 100 MA - 100 KV with all accessories. Michael Truman, M. D., 1070 Millville Ave., Hamilton, Ohio; 895-4541 or 895-9498.

FOR RENT: Office suite in new building, air-conditioned, on ground floor, ample parking. Located near hospital in community needing additional doctors. Reply Box 253, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER Interested in Psychiatry. Several staff openings exist at new NP Hospital activated last September in Greater Cleveland area. Expanding to 1,000 beds. Excellent working conditions and Federal service fringe benefits including cost of moving. Informal training provided by Board certified Psychiatrists. Salary dependent upon qualifications. Write: Director, VA Hospital, Brecksville 41, Ohio.

EXCELLENT OPPORTUNITY For someone interested in any practice in South-West Cleveland suburban; house-office with equipment, garage and parking place in front. Available from June 1st 1962. Box 265, c/o Ohio State Medical Journal.

EXCELLENT OPPORTUNITY For General Practitioner or Specialist. House-office combination with equipment including x-ray. Near hospitals in residential area of Cincinnati. At present occupied by General Practitioner, for 8 years; previously by pediatrician. Excellent corner location; swimming pool; newly decorated. Reasonably priced. Box 266, c/o Ohio State Medical Journal.

WANTED: Full time physician for large Railroad; to be located in Cincinnati. Graduate of Class A Medical School, 8 hours, 5 day week, vacation and fringe benefits. Box 267, c/o Ohio State Medical Journal.

FOR SALE or RENT: Excellent $50,000 gross General Practice: located Columbus Grove, Ohio; ten year old office-house combination; equipment; records; 20 car black-topped parking area; one acre landscaped yard; 6 acre fenced field; beautiful stable; riding ring. Good schools; 5 churches; excellent community; 2 good open staff hospitals in Lima, O., 12 miles southeast. Will introduce. R. B. Lucas, M. D., R. #3, Columbus Grove, Ohio.

PEDIATRICIAN, BOARD eligible, wanted in a two board member partnership of whom one will retire in July. New associate to have immediate partnership status if desired and assured percentage of earnings of a large practice. Location in nearby suburb of Cleveland in a prosperous growing residential area close to teaching institutions. Box 268, c/o Ohio State Medical Journal.

OBSTETRICIAN-GYNECOLOGIST; 33 years, married; completing approved residency June 1962, seeks situation. Association or group practice preferred. Write Full Particulars to Box 269, c/o Ohio State Medical Journal.

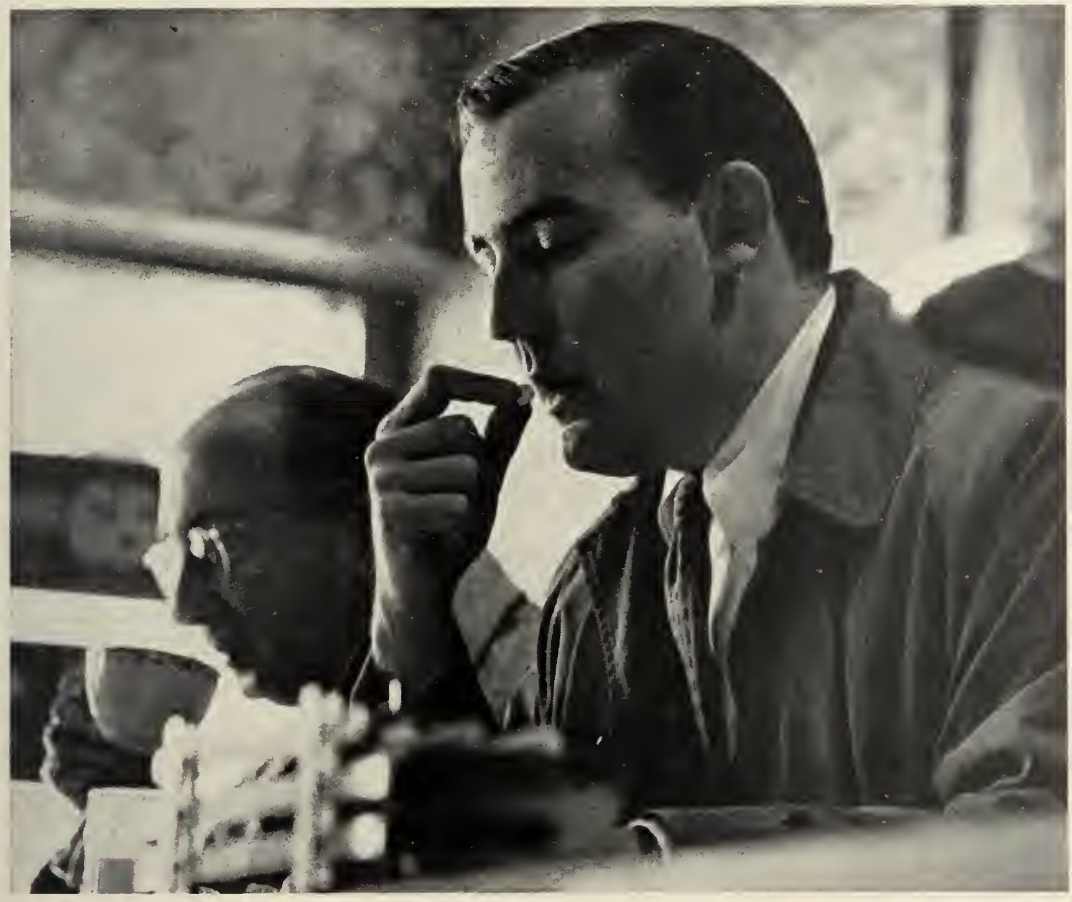
FOR RENT IN MARION, Ohio, a Clinic Building, in a good location that will accommodate 4 or more Physicians. The floor arrangement consists in the right wing of a large waiting room, a general office for Secretary-Bookkeeper, an ENT room equipped with an electric Retter outfit and accessories, an X-Ray and dark room, and a Clinical Laboratory. The left wing has a large room for EKG, BMR and an electric automatic apparatus which records the precise systolic and diastolic blood pressure. There are two separate rooms for GYN, proctologic and general examinations. The last room on the left is used for minor dressings, minor accident cases, and parenteral medication. There is a rest room for men in the right wing and one for women in the left. There is a drug room in the rear between the right and left wings and a small waiting room for the X-Ray Department and drug room. There is another small waiting room adjacent to the laboratory and still another small waiting room for minor dressings. The building is heated by a hot water system. The working equipment consists of chairs, desks, and filing equipment. There is GYN, Orthopedic, and general surgery equipment. The owner has a good sized parking lot which can be made available for Clinic patients. Box 270, Ohio State Medical Journal.



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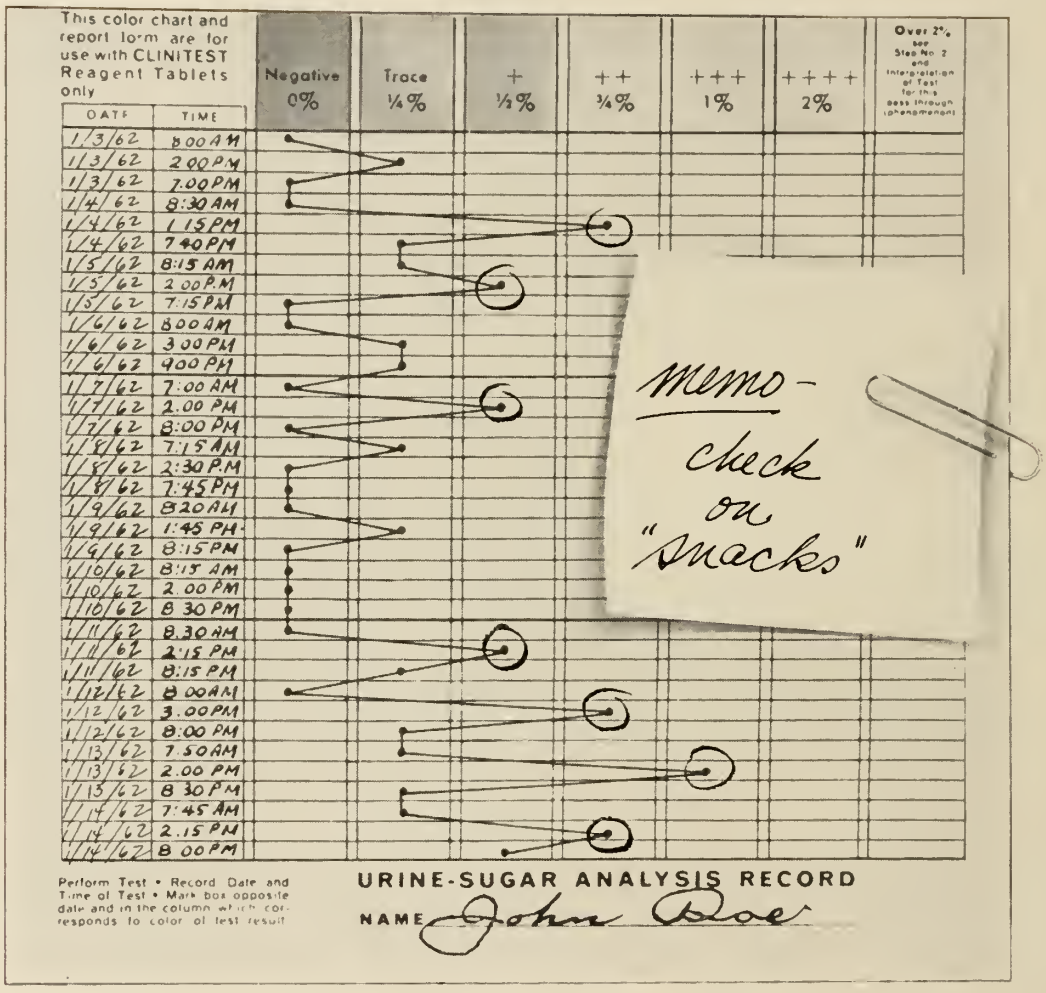
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*Schwartz, I. R.:
*Current Therap. Res.* 3:29, Feb., 1961.

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**cause of its higher antibacterial activity, and its effective-ss against a wide spectrum of bacteria.**

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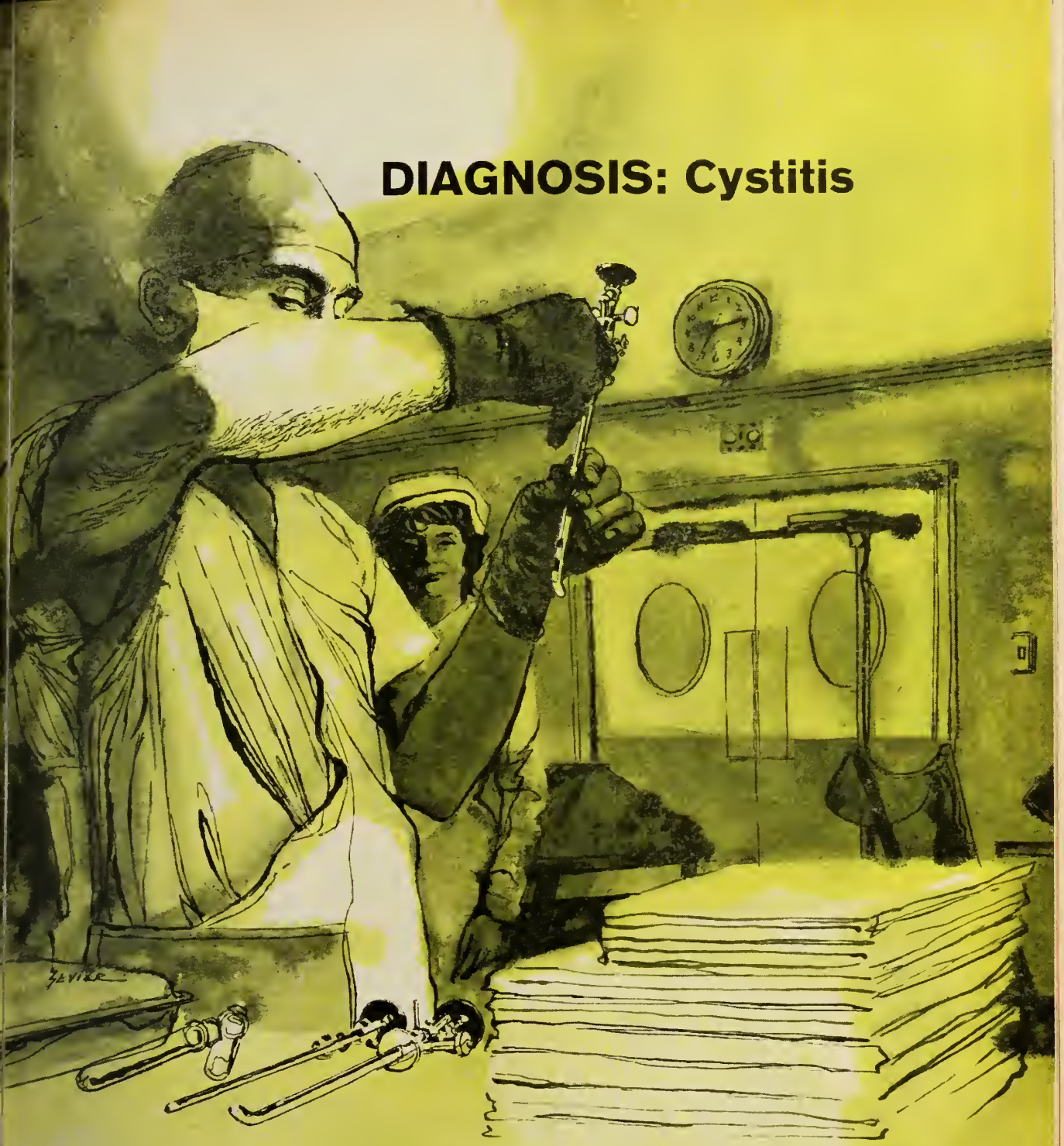
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# Health Services in the Community

**Administration Of Community Health Services,** Edited by Eugene A. Confrey, Public Health Advisor, United States Health Service, First Edition, 1961. ($7.50, *International City Managers' Association, 1313 East 60th Street, Chicago 37, Illinois.)* This is a joint undertaking of the American Public Health Association and the I.C.M.A. with the cooperation of the U. S. Public Health Service. The public health problems are approached from the point of view of the administrator — the city manager or the mayor or health administrator.

The book outlines the scope and methods of public health administration. It reviews the organization of community health services; it gives information and suggestions concerning the organization of local health departments; it suggests methods of making planning and evaluation studies; it discusses possible standards for rehabilitation, environmental health, dental health, public health nursing, and mental health programs; it helps to plan financing and priorities for needed improvements and expansion of health programs; and it presents material for use in public health education programs. These are all considered throughout 26 chapters dealing with as many public health topics.

Topics discussed are chronic diseases, maternal and child health, hospitals and the community, environmental health, nutrition, trends in community health services, financial management, organization, and planning and evaluation of health programs, among others.

Physicians and others especially interested in any of these subjects will find this book a valuable source of detailed information and authoritative recommendations.

**Contemporary Psychotherapies,** by Morris I. Stein. ($7.50, *The Free Press of Glencoe, Inc., Division of The Crowell-Collier Publishing Company, New York 11, N. Y.)* What are the significant issues in psychotherapy today? What are the theoretical orientations of the major therapies, and how are they applied to significant problems in the therapeutic process?

These questions are discussed here by 10 leading psychotherapists, who represent Adlerian, client-centered, existential, interactional, interpersonal, psychoanalytic, reparative - adaptational, and transactional psychotherapies. With one exception, each therapist has contributed two papers, one dealing with theory or some specific therapeutic problem, the other presenting a case discussion or a research study which applies the theory to actual practice.

In general, these are the matters discussed: the historical development of psychotherapeutic concepts; the characteristics of a helping relationship; the role of the therapist; transference and counter-transference; various methods of dealing with the patient's material; the relationship between diagnosis and treatment; measuring progress in psychotherapy; and current ideas about group therapy and family therapy.

This work has value for all who have either a professional's or a layman's interest in the current state of psychotherapy. Its worth is enhanced by the inclusion of material by men who have made significant original contributions in theory as well as in research.

**Physiotherapy for Foot Ailments,** by J. Hardy Stirling. ($3.00, *The Williams & Wilkins Company, Baltimore 2, Md.,* exclusive U. S. Agents.)

**Management of Obstetric Difficulties,** by J. Robert Willson, M. D. ($16.50, Sixth edition, *The C. V. Mosby Company, St. Louis 3, Mo.)*

**Pioneers In Mental Health,** by Robin McKown. ($3.25, *Dodd, Mead & Company, New York 16, New York.)*

**Marriage and the Family; College Outline Series, No. 87,** by Alfred McClung Lee and Elizabeth Briant Lee. ($2.25, *Barnes & Noble, Inc., New York 3, New York.)*

**The Image of Love,** by Clemens E. Benda, M. D. ($5.00, *The Free Press of Glencoe, Inc., A Division of The Crowell-Collier Publishing Company, New York 19, New York.)*

**Traitor Within: Our Suicide Problem,** by Edward Robb Ellis and George N. Allen. ($3.95, *Doubleday & Company, Inc., New York 22, N. Y.)*

**The Living Symbol: A Case Study in the Process of Individuation,** Bollingen Series LXIII, by Gerhard Adler. ($6.00, *Pantheon Books, Inc., New York 14, New York.)*

**Freud and Psychoanalysis;** Volume 4 of the Collected Works of C. G. Jung, Bollingen Series XX, by C. G. Jung, translator R. F. C. Hull. ($5.00, *Pantheon Books, Inc., New York 14, N. Y.)*



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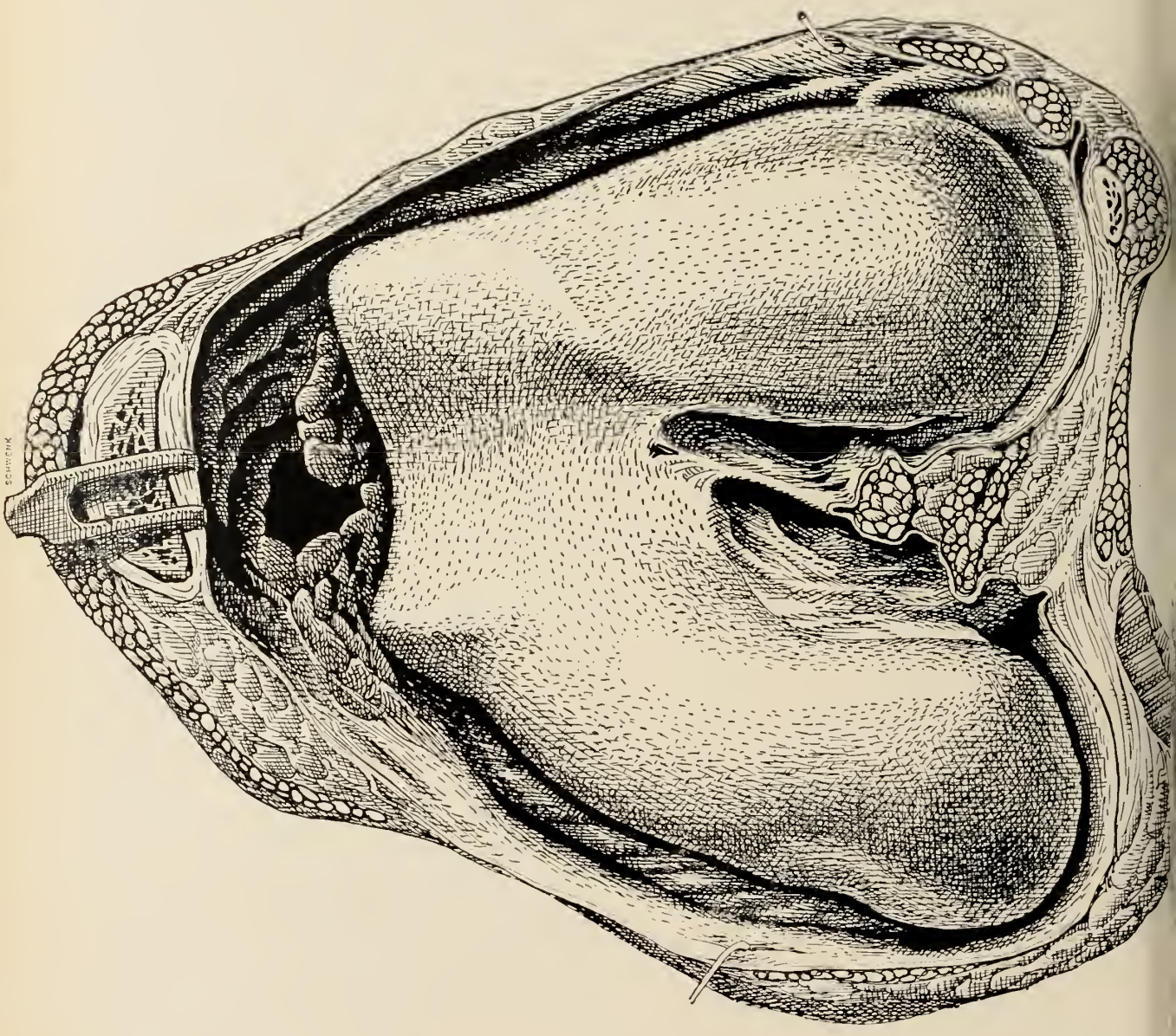
Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets.
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*The muscle relaxant with an independent pain-relieving action*

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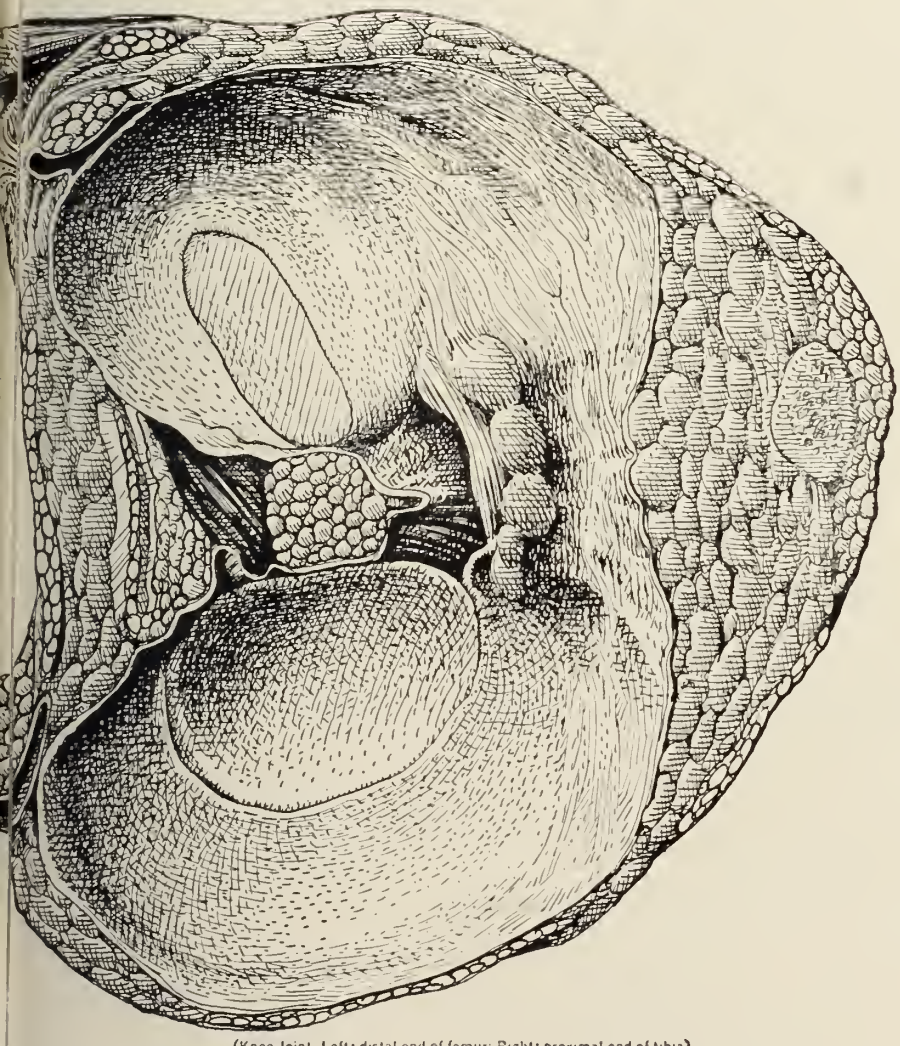
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Even cortisone, with its severe hormonal reactions, can effectively control inflammatory and rheumatoid symptoms. But a patient is more than the sum of his parts – and the joint is only part of a whole patient. Symptomatic control is but one aspect of modern corticotherapy, because what is good for the symptom may also be bad for the patient.

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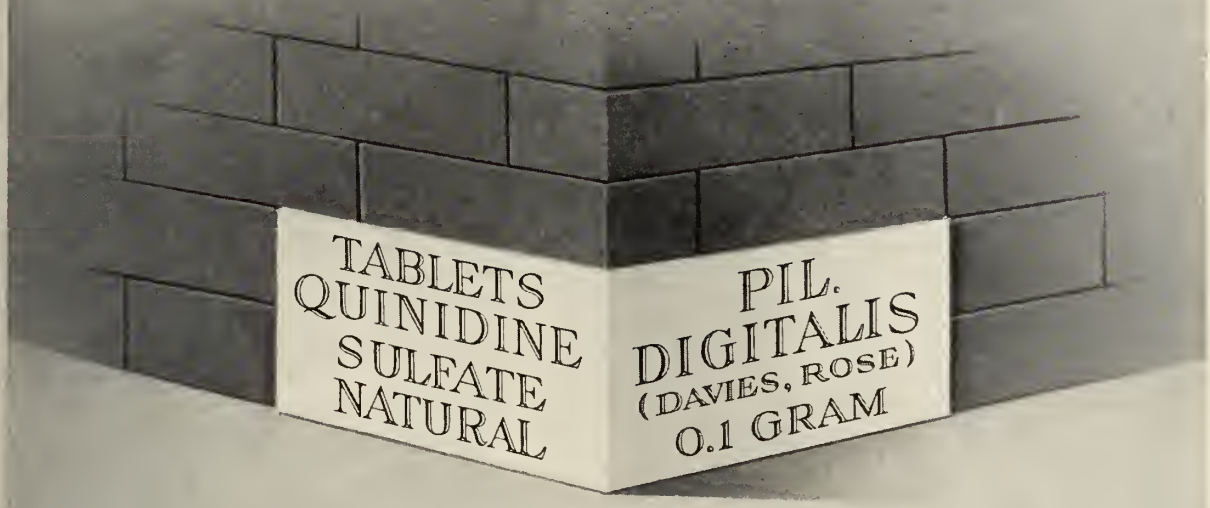
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**ERAPEUTIC NEED: Suppression of the causative organ-**
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# New Members . . .

The following are the names of the new members of The Ohio State Medical Association since March 1, 1962. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Butler**

James A. Goldey, Oxford
Stanley M. Goodman, Hamilton
Walter H. Roehll, Jr., Middletown
Louis H. Skimming, II, Middletown

**Clark**

Silvester Gilbert, Jr., Springfield
Gerard E. Gurnick, New Carlisle

**Cuyahoga**

Richard J. Beargie, Cleveland
Richard E. Braucher, Cleveland
Ali Gharib, Cleveland
Florentino T. Ibabao, Cleveland
Shinjiro A. Kimura, Cleveland
Nilda Mata - Lopez, Cleveland
Raul E. Montero, Cleveland
Satoru Nakamoto, Cleveland
Nina Nikitina, Cleveland
Tet Hyum Pang, Cleveland
Margit N. Prehal, Cleveland
August J. Vana, Bedford
Hastings K. Wright, Cleveland

**Fairfield**

Paul E. McMullen, Pickerington

**Franklin**

James V. Dindot, Reynoldsburg
John F. Dotter, Columbus
John D. Guyton, Columbus
Wilfried M. Kokott, Columbus
William L. Licklider, Columbus
Colin R. Macpherson, Columbus
Charles H. Neilson, Westerville
William C. Rigsby, Columbus
Thomas D. Stevenson, Jr., Columbus

**Hamilton**

Israel M. Dizenhuz, Cincinnati
John L. Friedman, Cincinnati
Charles Carter Patterson, Cincinnati
Robert A. Pornoy, Cincinnati

**Lorain**

Irwin M. Suna, Elyria

**Lucas**

Ernest G. Brookfield, Toledo
Daniel J. Hanson, Toledo
Daniel Kornblum, Toledo
Harvey E. Muehlenbeck, Toledo
Herschel E. Richardson, Toledo
Sheldon J. Schachner, Toledo
Donald Stepniewski, Toledo
John F. Sundermeyer, Toledo
Dorrence C. Talbut, Toledo

**Mahoning**

Harold J. Hassel, Youngstown
Engelbert Hecker, Youngstown
Elias T. Saadi, Youngstown

**Medina**

Liborio Marty, Cleveland

**Miami**

Harold G. Foss, Troy

**Montgomery**

Dean R. Johnson, Dayton
Henry G. Stein, Dayton

**Muskingum**

Alfred L. Coles, Zanesville

**Preble**

Willard C. Clark, Jr., Eaton

**Putnam**

Oliver N. Lugibihl, Pandora

**Shelby**

Getsy Cordova - Ferrer, Russia

**Stark**

Murray M. Bett, Canton
Jose A. de Cardenas, Canton
Sara C. de Cardenas, Canton
Huseyin Sarikaya, Canton

**Summit**

John W. Bohley, Akron
John J. Dettling, Akron
Charles W. Kinzer, Jr., New York
Robert Littlejohn, Barberton
George P. Mortier, Cuyahoga Falls

## Scholarship Awards Granted To Faculty Members

Twenty-five young medical scientists, all faculty members of the medical schools in the United States and Canada, have been appointed Markle Scholars in Medical Science by the John and Mary R. Markle Foundation. A total of 330 men and women in 80 medical schools have been aided during the 15 years of the program through grants totaling $10 million.

In Ohio a grant went to Thomas W. Moir, assistant professor at Western Reserve University School of Medicine, Cleveland, for work in internal medicine.

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# *An important announcement to physicians who prescribe corticosteroids*

Organon's new technical process now makes one of the newer, most highly potent and well tolerated corticosteroids available at greatly reduced cost to your patients with allergic, arthritic or other inflammatory conditions.

This new product is being marketed under the trade name of HEXADROL, brand of dexamethasone 'Organon'. HEXADROL is now being offered to your pharmacist at a price which should make it available to your patients at a cost well within the price range of older generically prescribed corticosteroids. It is supplied as 0.75 mg. white scored tablets, in bottles of 100.

**If you have been prescribing the older corticosteroids—** such as prednisone, prednisolone, hydrocortisone or cortisone, and have hesitated to prescribe the newer corticosteroids because of economic consideration for your patients, you can now secure all of the clinical advantages of dexamethasone at approximately the same prescription expense. Mg. for mg., HEXADROL is approximately 6 times more potent than triamcinolone or methylprednisolone... 8 times more potent than prednisone or prednisolone... 28 times more potent than hydrocortisone... and 35 times more potent than cortisone.

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***'Organon'—your professional assurance of quality***
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# Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

| Location | Facility | Telephone |
|---|---|---|
| Akron | Children's Hospital<br>W. Bowery and W. Bechtel | BL 3-5531, Ext. 246 |
| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
| Toledo | Toledo Health Department<br>635 N. Erie St. | CH 4-1961—(Day)<br>EV 5-4661—(Night) |
| Youngstown | Emergency Room Dept.<br>St. Elizabeth Hospital<br>1044 Belmont Street | RI 6-7231<br>Ext. 220 |


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ESTABLISHED 1916
Asheville, North Carolina



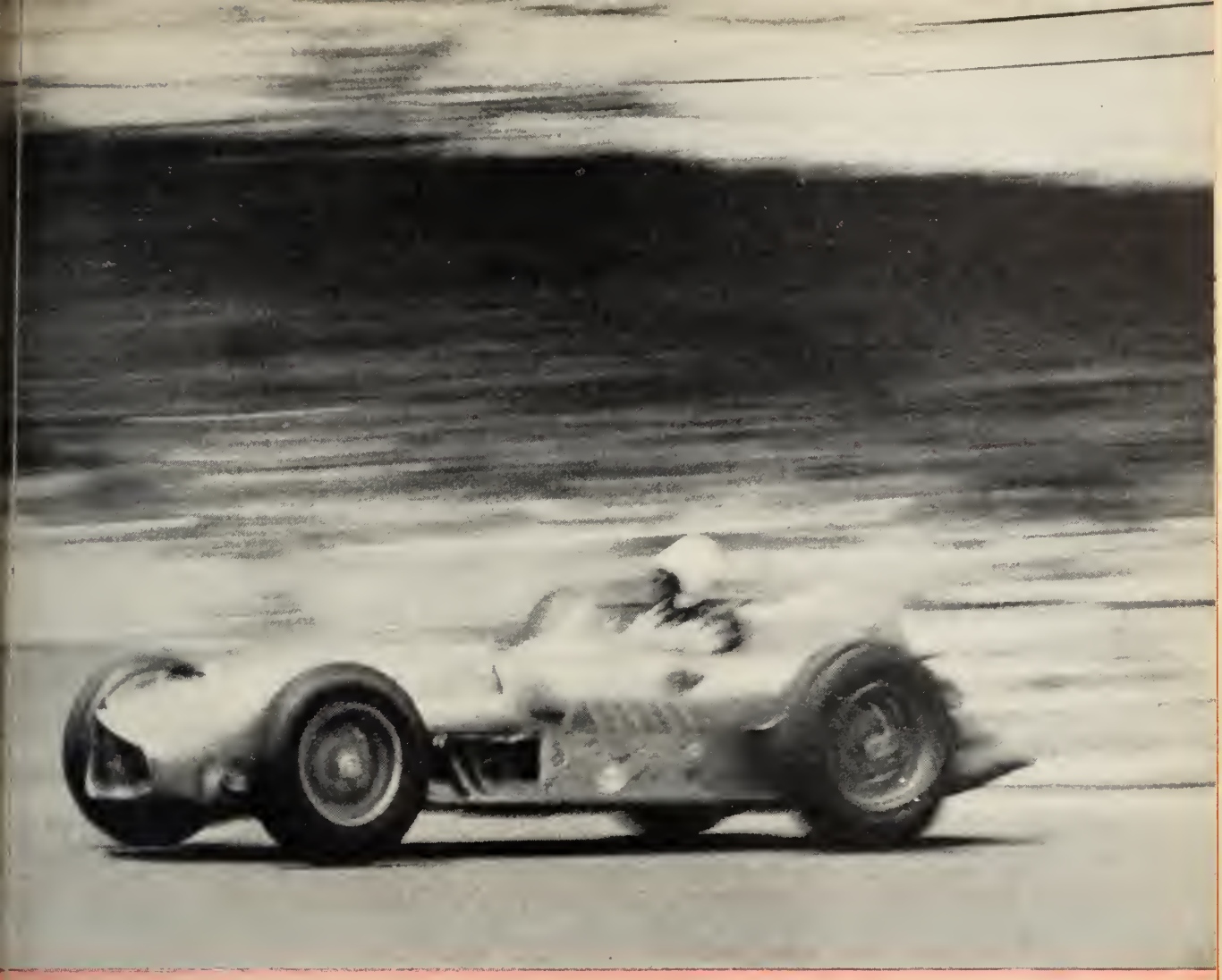
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■ acts in 5-15 minutes ■ relief usually lasts 6 hours or longer ■ constipation rare ■ sleep uninterrupted by pain

*Literature on request*

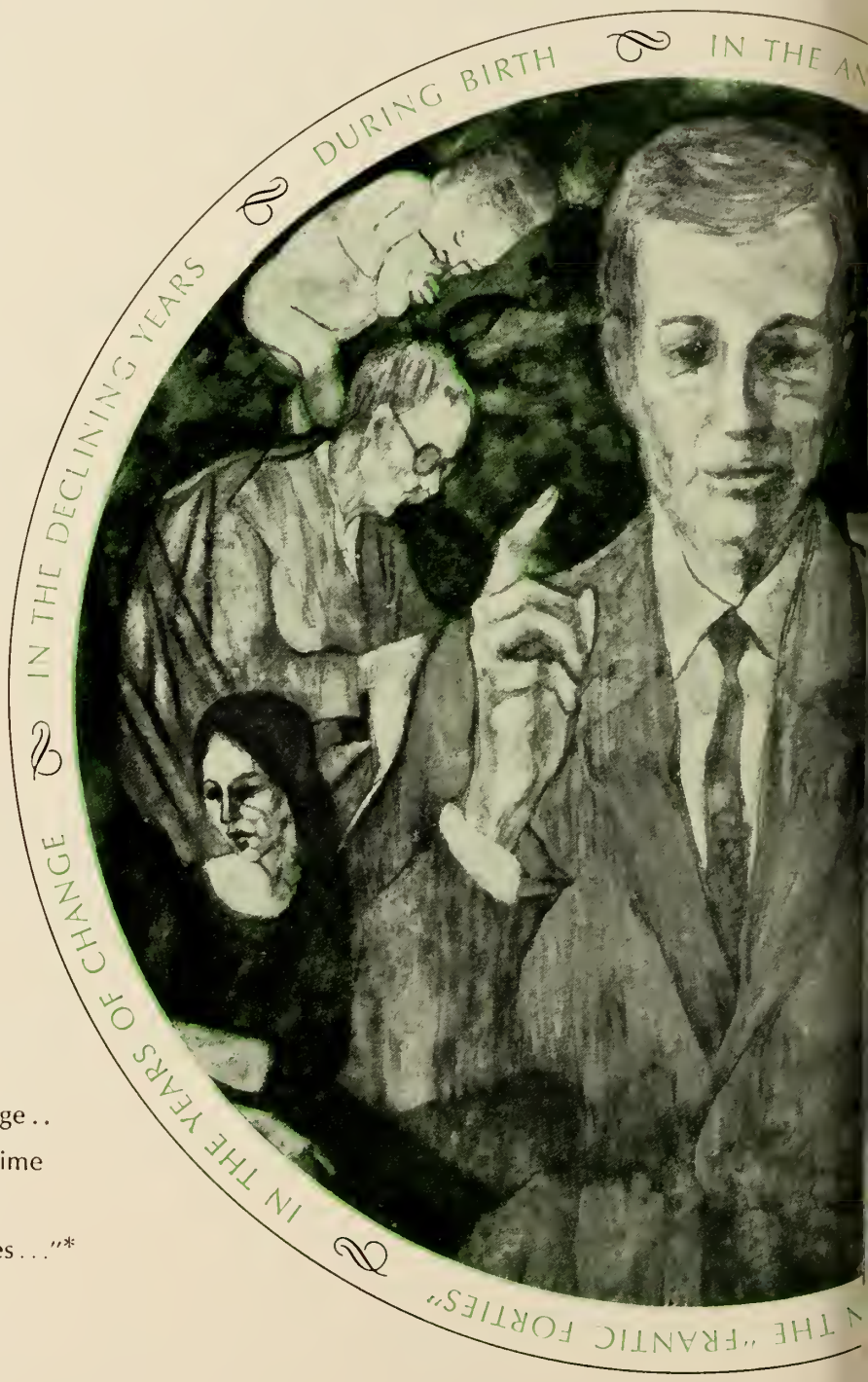
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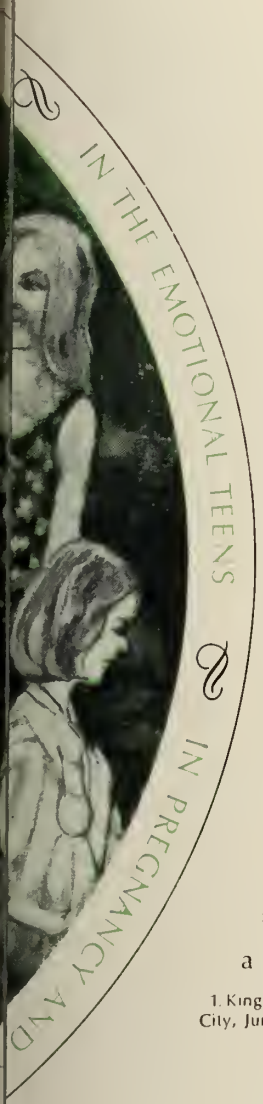

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*As You Like It, Act II, Sc. 7

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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**See "IN BRIEF" on the next page**

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Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

**SIDE EFFECTS:** Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

**PRECAUTIONS:** Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

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## Convention Highlights of Hospital Association

During the OHA Annual Convention in Toledo Sister Eugene Marie, S. C., administrator of Good Samaritan Hospital, Cincinnati, became the first nun to be elected president of the Ohio Hospital Association. As a tribute the Sister was installed by proxy since ill health prevents her from assuming the duties of office.

The office of President was then assumed by Edgar O. Mansfield, administrator of Riverside Methodist Hospital, Columbus, Ohio. Other officers elected were: President-Elect—Msgr. John C. Staunton, Cincinnati; First Vice-President—Sidney Lewine, Cleveland; Second Vice-President—James H. Moss, Cincinnati; Treasurer—Lee S. Lanpher, Cleveland; and Trustee at Large—John D. Connor, Columbus.

Before the banquet audience at the OHA Convention, Dr. Luther L. Terry, U. S. Surgeon General, painted a dramatic picture of what lies ahead in fields of health education and welfare. He foresees: Production of more physicians to meet nation's most urgent shortages in medical services . . . many additional millions of Americans covered by health insurance . . . fundamental reforms in the care of the mentally ill.

In a capsule, Dr. Terry told one phase of the hospital story which many have taken paragraphs to say. His remark: "The hospital buys as a profit-making business but must sell as a non-profit service." He added, "The dilemma of voluntary institutions with respect to costs and charges cannot be resolved by wishing it would go away. It is one of the major barriers in the provision of hospital and medical services throughout the country."

---

## National Survey of Prothrombin Announced by College

The therapeutic benefit from the widespread use of anticoagulant medication makes it imperative that prothrombin measurements be reproducible and that similar levels be used consistently in this country, an announcement from the College of American Pathologists states. In order to stimulate interest in the accuracy and precision of prothrombin measurements, the College of American Pathologists will conduct a national survey.

Those who wish to participate in the prothrombin survey may do so by applying to the Committee for Clinical Pathology Standards of the College of American Pathologists, Prudential Plaza, Chicago 1, Illinois. In addition to the survey samples, a critique on prothrombin measurements containing suggestions for increasing the reproducibility and accuracy will be sent to each participant.

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1. Ford, R. A., and Blanchard, K: Journal-Lancet 78:185, 1958

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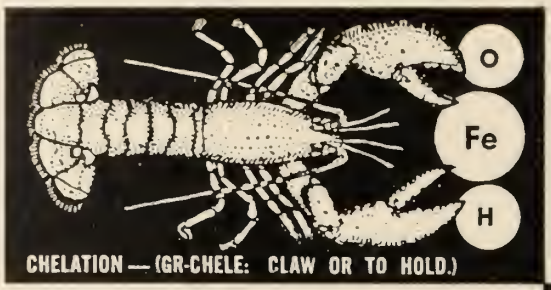
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| Zinc (as Zinc Betaine Citrate) | 1.25 mg. |
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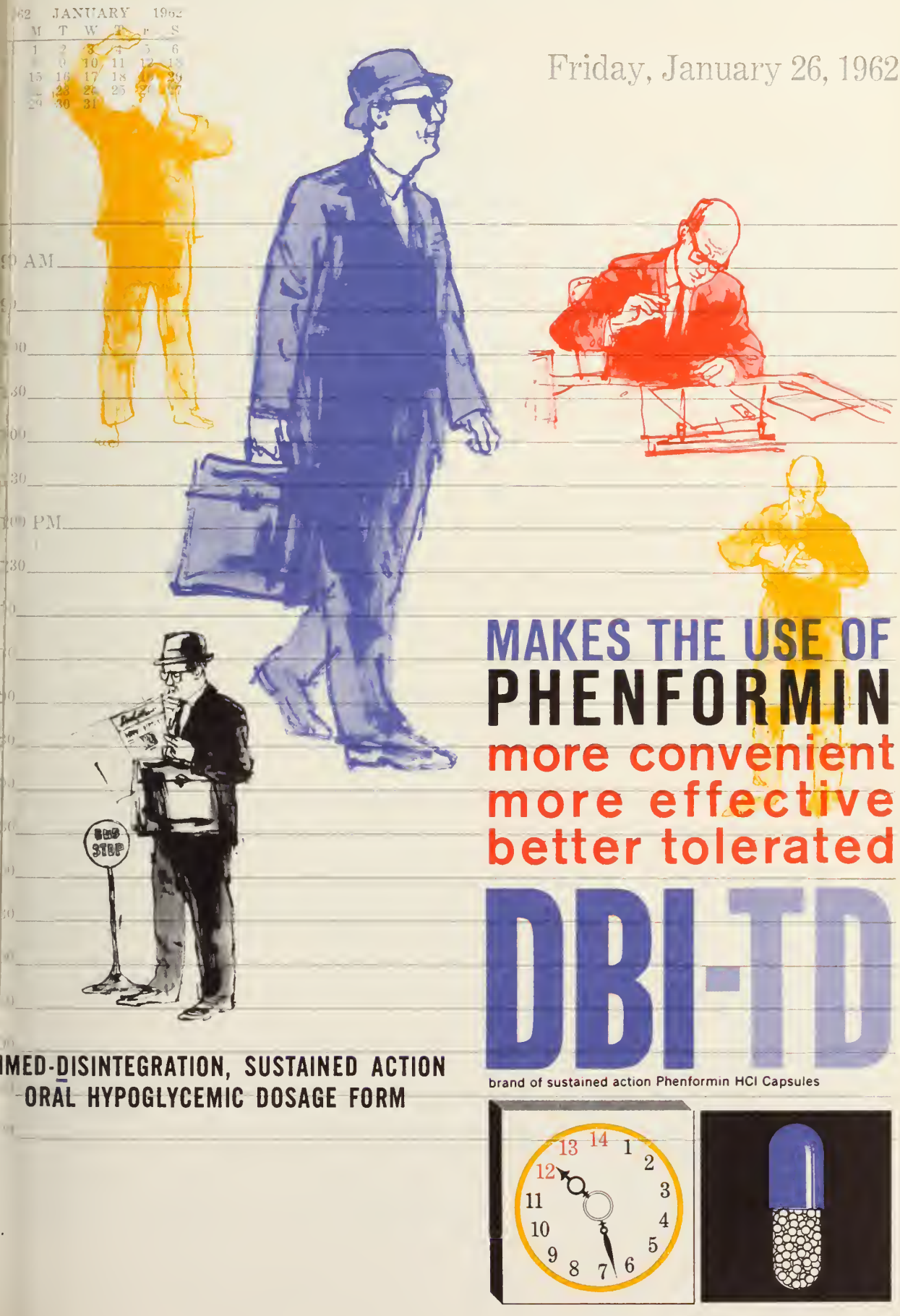
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1. Walker, R. S.: Brit. M. J. 2:405, 1959. 2. Pomeranze, J.: Clinical Medicine 8:1155, 1961. 3. Pearlman, W.: Phenformin Symposium, Houston Feb. 1959.

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# History of the Lakeside Unit Of World War I

HARRY D. PIERCY, M.D.*

## Part I

BASE HOSPITAL No. 4 U. S. A. was the first unit of the Army to see active service overseas in the First World War. This group of officers, enlisted men and nurses were the first of the two million and more troops transported to England and France after the declaration of war on April 6, 1917.

The Lakeside Unit was organized almost one year ahead of the order to mobilize. This was due to the foresight of Dr. George W. Crile of Cleveland, Ohio. The idea of the proper formation of Hospital Units in time of war grew out of his experience with the operating team he took from Lakeside Hospital, to the American Ambulance. This hospital was organized by the American colony in Paris and was situated in the suburb of Neuilly, sur Seine. It was supported by contributions from Americans living in Paris and in the United States. The hospital had three services of 150 beds each. It was staffed by French, English, and a few American medical men and had been receiving battle casualties since late in August 1914.

### The American Ambulance

In October 1914 Mr. Francis Drake, President of the American Chamber of Commerce in Paris, came to America to solicit funds for the support of the American Ambulance. He visited Lakeside Hospital in Cleveland and the operating rooms of Dr. Crile where he was much impressed with the operations done under nitrous oxide-oxygen anesthesia because of the ease of anesthetizing the patient and the promptness of recovery compared with the long induction period and the greatly delayed recovery in ether anesthesia. His visit here ended by his asking Dr. Crile to bring a surgical unit supplied with nitrous oxide and oxygen tanks to France to take a three month service on one of the three services in the American Ambulance.

### The Surgical Unit

This opportunity was eagerly grasped by Dr. Crile, and he and Dr. Wm. E. Lower organized the unit for military surgery. Dr. C. W. Stone, neurologist, was chosen and the operating team consisting of Drs. Samuel L. Ledbetter, Edward F. Keiger, Leroy B. Sherry and Lyman F. Huffman was taken from the surgical staff of Lakeside Hospital. In addition, Miss Agatha Hodgins and Miss Mabel Littleton, anesthetists, and Miss Iva B. Davidson and Miss Ruth J. Roberts, operating room nurses, and William B. Crozier and Miss Amy F. Rowland in laboratory research accompanied the unit. The expense of this unit, with the exception of Dr. Crile and Dr. Lower who paid their own expenses, was borne by Samuel Mather, President of the Board of Trustees of Lakeside Hospital. Mr. H. M. Hanna, a member of this Board, made a generous contribution of funds for research.

For years Dr. Crile had been observing the effects of fear and exhaustion on the bodies of animals, a study out of which had evolved his ideas of "anoci-association" and "shockless surgery." Up to this point he had no opportunity to observe the effects of fear and exhaustion on human beings and he approached this service in the war zone with great enthusiasm because there he would find abundant human material available for this fascinating study.

The surgical unit sailed on the *S. S. Adriatic* on December 30, 1914 and by January 10, 1915 was operating as they had at Lakeside Hospital using nitrous oxide-oxygen anesthesia and giving blood transfusions by the cannula method. This was the first use of blood transfusions in the British and French Military Hospitals. The hospital was filled with battle casualties presenting every type of wound in troops who were exhausted physically and nervously by the nine days retreat from Mons, Charleroi and the Marne.

### Army Base Hospitals

The experience at the American Ambulance convinced Dr. Crile that the efficient Army Base Hospital should be staffed by men who had worked together and had thereby developed an esprit de corps, and that the same considerations should apply to the anesthetists and operating room nurses. This marked

*Dr. Piercy, Cleveland, is a member of the courtesy staffs of University Hospitals, and St. Luke's Hospital, Cleveland, Ohio.
Submitted June 23, 1961.




Simon, F. & Bernstein, A.: "The Treotment of Obesity in Potients with Cordiovoscular Diseose," Angiology, 32-37, Jon. 1961.

Plotz, M.: Modern Management of Obesity, J.A.M.A., 170:1513-1515 (July 25) 1959.

Bernstein, A. & Simon, F.: "Treotment of Obese Diobetics ond Arteriosclerotics," Clinicol Medicine, 907-920, Moy 1961.

the beginning of the "Hospital Unit Plan of Organization of the Medical Reserve Corps of the U. S. Army for service in Base Hospitals."

The Surgeon General, W. C. Gorgas, was convinced of the soundness of this idea and after further correspondence and consultations with Dr. Crile the plan gained much publicity and the American Red Cross initiated the formation of Base Hospital Units in the various civilian hospitals throughout the country. Col. Jefferson R. Kean, M. C., U. S. A., was assigned to the Red Cross for this purpose.

### The Lakeside Unit is Organized

In March 1916, Lakeside Hospital signed an agreement with the Red Cross whereby the hospital would assemble a trained personnel for a 500 bed Army Base Hospital, agreeing to keep this organization fully staffed and ready to respond to the call of the Red Cross.

The summer of 1916 was spent in organizing the professional component of the Lakeside Unit: medical officers and nurses. About July 1st, a muster roll was sent to Col. Kean for transmission to the Surgeon General. The medical officers received commissions in the medical corps of the Army and the nurses were enrolled in the Red Cross. The Lakeside Unit was designated as U. S. Army Base Hospital No. 4.

An experimental mobilization of this hospital was held in Fairmount Park in Philadelphia on October 27 to 29, 1916. Tentage had been erected and surgical and other equipment had been brought from the Red Cross depot at the Brush Terminal, Brooklyn, N. Y. The program for a functioning War Hospital was carried out, and fictitious cases of wounded and ill soldiers were put through the hospital. Full records were kept of all activities. This trial and error mobilization disclosed defects and unsuspected needs, and called out suggestions and comments which were discussed, discarded or adopted.

This exercise led to the establishment of a commitee on the standardization of medical supplies and equipment. Drs. Crile, Harvey Cushing, John Finney and Will Mayo served on this committee to consult with the Surgeon General regarding the needs of the Base Hospitals in Wartime. This resulted in greatly speeding up the medical preparations for war and when war was declared, the medical organization was well in hand and the first units were promptly dispatched to France, for the British Command called for Base Hospitals and medical supplies as being the most helpful first contribution our country could make to the war effort.[1]

### Mobilization Order Received

On April 28, twenty-two days after the declaration of war, Dr. Crile received a telegram from General Gorgas asking for the earliest possible date Base Hospital Number 4 could be mobilized for duty. Col. Kean telegraphed that he hoped we could be ready in 10 days, to which Dr. Crile replied: "Mobilization order received; Base Hospital Number 4 is ready to move within desired time."

Then followed a busy week. An enlistment office was set up in the dispensary at Lakeside Hospital. Men from the city, from Adelbert and other colleges in Ohio and Pennsylvania poured in, and 155 were enrolled within a few days. Of these, more than half were college men who were eager to join the first unit to be dispatched to France. They were not "pick and shovel" men and all would have been accepted in the Officer Training Schools that were shortly set up in the various states. After arrival in France about 30 of them were selected for training in the Sanitary Corps and received commissions.

### The Unit Sails for England

On May 3 Colonel Harry L. Gilchrist, Medical Corps U. S. Army, arrived to take command. Colonel Gilchrist was an alumnus of the Western Reserve Medical School, class of 1896. On May 6, eight days after receipt of the first order to mobilize, the entire personnel of the Base Hospital, 27 officers, the enlisted men, 64 nurses and four civilian employees, entrained in Cleveland. The train ran on military orders on cleared tracks to Jersey City and from there they went by ferry to the Cunard docks where they boarded *H. M. S. Orduna* which was painted a battleship gray and carried a gun astern. The ship sailed on the eighth.

The next morning the whole command was called together and Col. Gilchrist read the Articles of War. After this some rather intensive military training was given these raw recruits. The men were drilled morning and afternoon and the commands of "fours right," "fours left," "left face" et cetera, were heard over the decks several hours each day. The drum and bugle corps trained equally hard and more discordantly. The *Orduna* docked at Liverpool, England on May 18. The Unit disembarked and was given an enthusiastic welcome at the dock. The enlisted men were sent to Blackpool. The officers and nurses were sent to London, and on May 23 they were received by the King and Queen of England at Buckingham Palace. In the afternoon of the same day the nurses were presented to Queen Mother Alexandra at Marlborough House. The enlisted men in Blackpool were given a welcome that left pleasant and enduring memories.

The enthusiasm and the courtesy with which this Unit was received in England was touching, and significant of the symbol it represented: the actual participation of America in the war, which with the increasing submarine menace, the military failure of Russia, and the settled entrenchment of both belligerents, had reached a condition suggestive of stalemate.

*(To Be Continued in June Issue)*

### Reference

1. Crile, Grace (editor): George Crile. Philadelphia, J. B. Lippincott Co., 1947, vol. 1, p. 247 et seq.

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STUDY 3 *Weissberg, G.: Clin. Med. 7:1161, 1960.*

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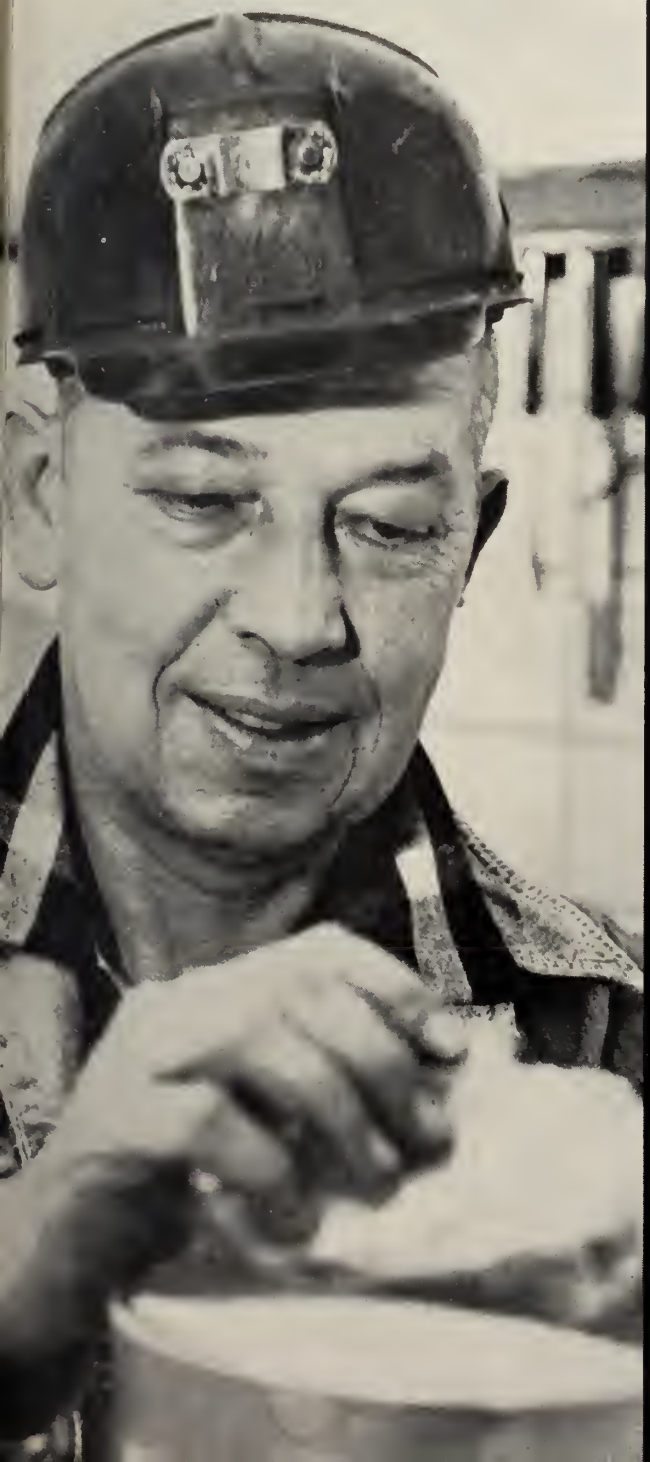
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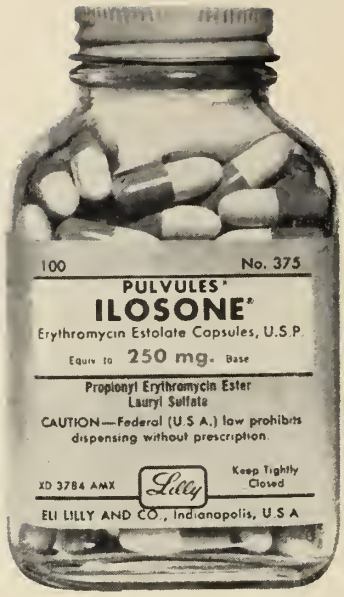


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# Galactosemia: An Inherited Metabolic Disorder

## I. Diagnosis of Congenital Galactosemia

HELEN K. BERRY, M.A., and GEORGE M. GUEST, M.D.

## II. Galactosemia: A Clinical Report

EUGENE PERRIN, M.D.

### I. DIAGNOSIS OF CONGENITAL GALACTOSEMIA

GALACTOSEMIA is an inherited metabolic disorder in which an affected child is unable to metabolize galactose, one of the monosaccharides derived from lactose, or milk sugar. The pathways for galactose metabolism have been well established.[1] Galactose is phosphorylated to galactose-1-phosphate which reacts with uridine diphosphoglucose to produce glucose-1-phosphate and uridine diphosphoglucose.

The enzyme which catalyzes the transfer of phosphate from galactose to glucose, galactose-1-phosphate uridyl transferase, is deficient in galactosemic individuals. As a result galactose phosphate accumulates in cells and tissues. This inability to metabolize dietary galactose leads to clinical signs of varying severity. Galactosemia in infants may produce jaundice persisting beyond the usual "physiological" period, followed by hepatomegaly, splenomegaly, and ascites and often leads to death within a few weeks or months. In less severe manifestations the disease may result in feeding difficulties, growth failure, cataracts, and mental retardation. Mellituria is usually found but may be absent if the child is severely ill. Some children with galactosemia die in the first weeks of life, occasionally even after correct diagnosis has been made and a dietary regimen established. The cause of death is often sepsis and the organism involved is usually a gram-negative bacillus.

Identification of urinary sugar as galactose suggests a tentative diagnosis of galactosemia. An unknown reducing substance in the urine can readily be identified by chromatographic methods.[2] Figure 1 shows

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From the Children's Hospital Research Foundation and the Departments of Pediatrics and Pathology, The University of Cincinnati College of Medicine. Submitted September 19, 1962.

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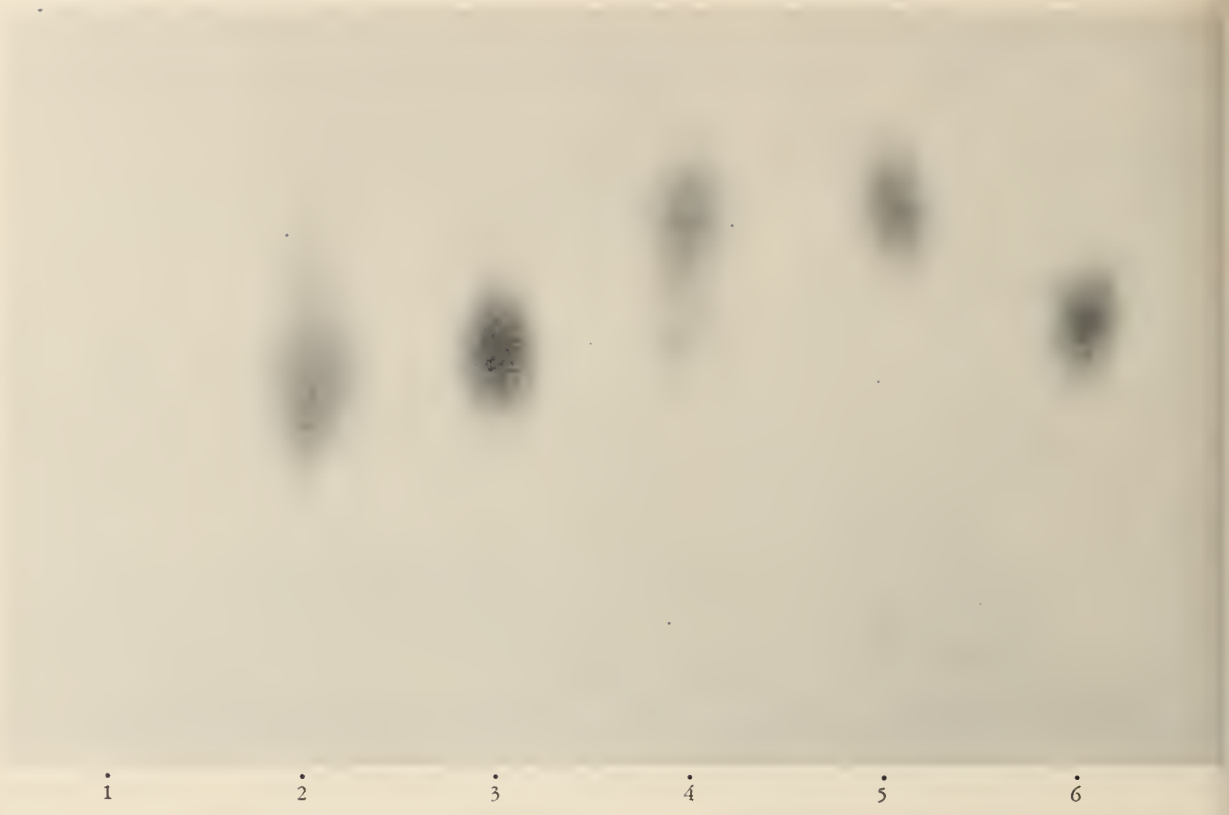



FIG. 1. *Spot 1: 5 λ of urine containing unknown sugar.*
*Spot 2: 25 λ of urine containing unknown sugar.*
*Spot 3: 5 λ of urine containing unknown sugar + standard galactose solution*
*Spot 4: 5 λ of urine containing unknown sugar + standard glucose solution*
*Spot 5: 5 λ of standard glucose solution applied (25 γ)*
*Spot 6: 5 λ of standard galactose solution applied (25 γ)*
*Solvent: Butanol-pyridine-water (80-80-40)*
*Reagent: Aniline-phthalate*

a chromatogram of urine from a child with galactose disease.

It is now possible to measure the activity of galactose-1-phosphate uridyl transferase in erythrocytes, a tissue which is readily available. This offers a specific diagnostic test for congenital galactosemia.[3] A deficiency of the enzyme can be demonstrated in affected individuals, even in cord blood obtained at birth.

A reduction in the activity of galactose-1-phosphate uridyl transferase in erythrocytes from parents of galactosemic children has been reported by several investigators.[4,5] Hugh-Jones, et al.[6] reported studies on three generations in a galactosemic family. The apparently heterozygous individuals had enzyme levels one-third to one-half those of normal persons. These heterozygotes were unusual in that they exhibited milk intolerance and occasional galactosuria. Galactosemia is inherited as a Mendelian recessive trait. In an affected family there is a 25 per cent chance that a newborn infant may have the disease.

## Material and Method

The records of Children's Hospital during the past 16 years reveal 12 children with galactosemia ranging in age from 3 to 14 years. Once a fairly simple diagnostic procedure became available it was possible to re-examine a number of these children. Six were available for study. A number of other infants came to our attention as a result of the study.

Heparinized blood was obtained from the patients and from siblings or parents. The erythrocytes were separated by centrifugation in the cold and washed twice with cold saline. The cells were hemolysed by addition of an equal volume of distilled water, then frozen. The enzyme measurements were carried out on the hemolysate as recommended by Kalckar.[7]

## Results

The results of studies on a number of individuals, both normal and galactosemic, are summarized in Tables 1 - 3. The children previously diagnosed as galactosemic had enzyme levels at 0.0 to 0.34. The range reported for normal individuals is 1.7 to 9.0, and for galactosemic individuals is 0 to 0.5.[7] The diagnosis of galactosemia was thus confirmed in these patients by demonstration of zero or very low enzyme levels.

The results of measurement of enzyme activity in 10 infants with symptoms suggestive of galactosemia are shown in Table 2. In four infants the enzyme

concentration was normal. In six infants the enzyme was absent or present in inadequate concentration, and a diagnosis of galactosemia was made. Five of these were treated by removal of milk from the diet. In one instance the disease was not recognized until the severe physical manifestations were irreversible. The four infants with normal enzyme levels were non-galactosemic. Their disorders were later diagnosed as biliary atresia in one instance, giant cell hepatitis in another and hepatitis, unknown etiology, in the remaining two infants.

Our data on relatives of galactosemic children are insufficient to assess the heterozygous carriers. However, low concentration of enzyme (1.4 units) in the mother of suspected infant I, Table 2, is of interest. A sibling born in 1954 died at age 7 months with symptoms of galactosemia, including galactosuria, aminoaciduria, jaundice, hepatomegaly, and ascites. Another infant born in 1958 was tested for galactose enzyme at age 2 months. The enzyme concentration then was 2.5 units/Gm. hemoglobin. The presence of clinical symptoms of vomiting, jaundice, and hepatomegaly (but no galactosuria or aminoaciduria) may be related to the smaller amount of

TABLE 1. *Enzyme Concentration in Erythrocytes from Galactosemic Patients and Relatives*

| *Galactosemic Patients Previously Diagnosed* Family | | Age | Galactose-1-Phosphate uridyl transferase units/Gm. hemoglobin | Remarks |
|---|---|---|---|---|
| I Patient | (F) | 3 Yrs | 0 | Diagnosed at age 6 weeks; cataracts. |
| Sib 1 | (F) | 4 Yrs | 4.2 | |
| Sib 2 | (M) | cord blood | 3.2 | |
| Sib 3 | (F) | 2 weeks | 0 | Died (See Case Report). |
| Mother | | | 5.5 | |
| II Patient | (M) | 4 yrs | 0 | Abnormal galactose tolerance test. |
| Sib 1 | (F) | 13 Yrs | .34 | Mental and physical retardation. |
| III Patient | (M) | 5 Yrs | 0 | Retarded: poor growth. |
| Sib | (M) | 2 mos. | 3.2 | |
| IV Patient | (M) | 6 Yrs | .04 | |
| V Patient | (M) | 14 Yrs | .10 | Diagnosed at age 6 weeks. |
| VI Patient | (F) | 3 Yrs | .14 | Reducing substance in urine (negative to glucose oxidase tests) Mental and physical retardation. |

TABLE 2. *Enzyme Concentration in Erythrocytes from Infants Suspected of Having Galactosemia and from Their Relatives*

| *Suspected Infants* Family | | Age | Galactose-1-Phosphate uridyl transferase units/Gm. hemoglobin | Remarks |
|---|---|---|---|---|
| I Infant | (M) | 2 days | .84 | Sibling died 7 years ago with suspected galactosemia, jaundice, hepatomegaly, ascites. |
| Sib | (M) | 2 mos | 2.5 | Vomiting, jaundice, hepatomegaly. |
| Mother | | | 1.4 | |
| Father | | | 7.8 | |
| II Infant | (F) | 2 mos | 0 | Reducing substance in urine (not glucose). |
| Sib | (F) | 6 wks | 5.0 | No symptoms. |
| Half-sib | (M) | 4 wks | 3.7 | No symptoms. |
| III Infant | (M) | 4 wks | 4.0 | Cataracts. |
| IV Infant | (M) | 24 days | 6.8 | Transient sugar (3+) in urine, vomiting, jaundice, cataracts. |
| V Infant | (F) | 4 wks | 0 | Jaundice, ascites; died. |
| VI Infant | (M) | 3½ mos | 4.7 | Reducing substance in urine; Hepatomegaly, jaundice; died. |
| VII Infant | (M) | 2 mos | 3.5 | Hepatomegaly, jaundice. |
| VIII Infant | (M) | 29 days | .5 | Jaundice, hepatomegaly, ascites. |
| IX Infant | (M) | 8 days | 0 | Sugar in urine (4+) negative to glucose oxidase. |
| X Infant | (F) | 4 wks | 0 | Hepatomegaly; galactose in urine. |

TABLE 3. *Enzyme Concentration in Erythrocytes from Random Controls*

| *Random Controls* Family | | Age | Galactose-1-Phosphate uridyl transferase units/Gm. hemoglobin | Remarks |
|---|---|---|---|---|
| Infant | (M) | 12 days | 9.2 | Erythroblastosis. |
| Infant | (F) | 4 days | 3.4 | Erythroblastosis; exchanged. |
| Control 1 | (M) | 5 yrs | 9.7 | Phenylketonuric. |
| 2 | (F) | 14 yrs | 5.4 | Diabetic; cataracts. |
| 3 | (M) | 10 mos | 2.2 | Cataracts. |
| 4 | (M) | 2 yrs | 2.3 | Cataracts; hepatomegaly, mental and physical retardation (Lowe's disease). |
| 5 | (M) | 5 yrs | 8.1 | Cataracts; mental and physical retardation (suspected Lowe's disease). |
| 6 | (M) | 1 yr | 12.0 | Cataracts; hepatomegaly. |
| 7 | (F) | 30 yrs | 6.3 | Normal. |

enzyme. Likewise, the coincidence of cataracts and low enzyme levels in two children shown in Table 3 deserves further study.

These data suggest that further information on relatives of galactosemic patients is needed. It should be determined if the heterozygous carrier has clinical symptoms of galactosemia in infancy which may be "outgrown" as the total amount of enzyme in the body increases with increasing size or as the milk intake is reduced.

## Discussion

Although it is now possible to diagnose galactose disease early in life, the precaution of measuring enzyme activity is not always taken. Galactosemia should be suspected in an infant with mellituria, particularly if accompanied by persistent jaundice, hepatomegaly, cataracts, and a history of vomiting. Even in families with children already known to have galactosemia the need for testing each subsequent infant is often overlooked. The first patient in Family 1, Table 1, born in 1955, had been treated from infancy for galactosemia. A sibling, born in 1954, tested at age 4 years, had a normal complement of enzyme. Erythrocytes from the cord blood of an infant born in 1958 had normal activity of galactose-1-phosphate uridyl transferase. In 1960 an infant was born into this family, but was not tested immediately. A brief report of this latter infant is presented in part II.

Galactosemia, like phenylketonuria and cretinism, represents an inherited metabolic disorder which can be detected in early infancy. If carefully treated by rigid exclusion of lactose and galactose the deleterious effects of the disease, whether neonatal death or mental and physical retardation with cataracts, can be prevented or minimized. Simple screening tests for sugar excretion by infants during the early weeks of life would reveal galactosuria.[8] In families in which the disease is already known, much anxious waiting on the part of the parents could be avoided by measurement of galactose-1-phosphate uridyl transferase activity in erythrocytes from cord blood.

## II

## GALACTOSEMIA: A CLINICAL REPORT

**Family I, Sib 3 (F);** Birthdate: August 27, 1960.

On the seventh day of life, this otherwise normal white female infant became jaundiced and listless. On the morning of admission to The Cincinnati Children's Hospital the baby became more jaundiced and listless, and occasional groaning respirations were heard. The formula was changed from a standard proprietary milk (Enfamil) to a soybean "milk" (Sobee), and the new formula was well tolerated. Diarrhea was not observed. The infant vomited once on the evening of admission.

Pregnancy and delivery were not abnormal. The child weighed 6 pounds 1 ounce at birth and did not require resuscitation. Weight upon admission to the hospital was 5 pounds. The infant was icteric and in respiratory distress.

Corneal or lenticular opacities were not seen. There was moderate subcostal retraction with rapid respirations, but no rales were heard. A soft, grade 1 systolic pulmonic murmur was heard. The abdomen was distended, and the large firm liver was palpable 5 cm. below the costal margin. Suck and Moro reflexes were absent.

Family history was not remarkable except for the patient's oldest sib, one of four. In this child, 5 years of age at the time of the patient's death, galactosemia had been diagnosed



FIG. 2. *Liver; H & E; x 75. Sib 3, Family I; died on 10th day of life; massive fatty metamorphosis; known galactosemic.*

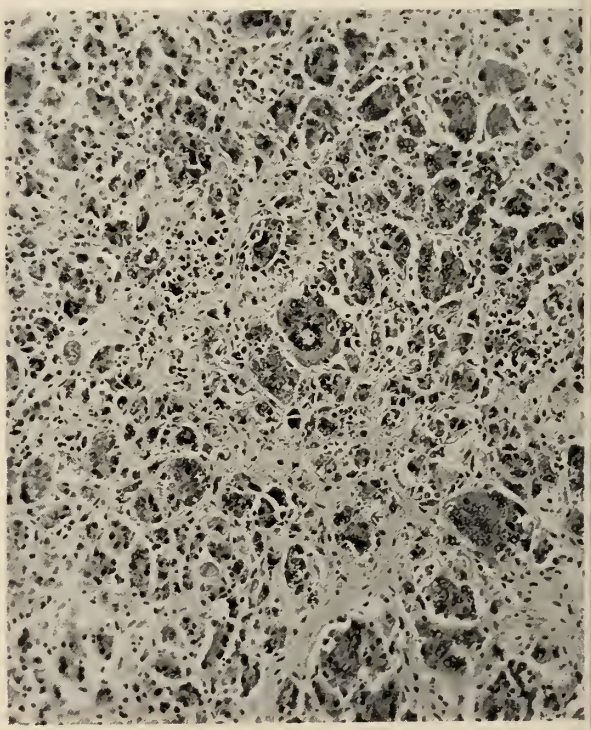


FIG. 3. *Liver; H & E; x 160. Female infant, Family VIII; died at 3 months of age; central "pseudoacinar" arrangement, fibrosis; possible transplacental hepatitis; known galactosemic. (Brother of patient, Sib M, has healed neonatal hepatitis without galactosemia.)*

in infancy and treated with soybean milk. However, she had cataracts at age 5 and was somewhat mentally retarded.

## Laboratory Studies

Hemoglobin was 15.4 Gm. per 100 ml.; white blood cell count 9,050, with 52 per cent neutrophils and 47 per cent lymphocytes. $CO_2$ content was 12.8 mEq/liter; chloride 128 mEq/L; sodium 150 mEq/L; blood glucose 64 mg. per 100 ml. and urea nitrogen 32 mg. per 100 ml., indicative of dehydration. Cerebrospinal fluid was xanthochromic and contained 0.2 Gm. per 100 ml. of protein, 100 mg./100 ml. of glucose and 120 mEq./L of chloride. Urine was "negative" for sugar by Clinitest® (reducing substances) and Tes-Tape® (glucose-oxidase paper specific for glucose).

The child was treated with intravenous penicillin, chloramphenicol, and fluids for "sepsis" but did not improve and died eight hours later.

Antemortem and postmortem blood cultures yielded a significant number of colonies of "nonpathogenic type" E. coli.

A complete autopsy was performed. Significant findings were limited to lungs and liver. Questionably significant pallor and fraying was noted in sections of basal ganglia and spinal cord.

The liver weighed 95 grams (normal for weight 115) and was soft. Its cut surface was mottled, with a fine orange-green accentuation of lobular architecture. Liver sections, formalin-paraffin and fixed-frozen, were marked by fatty "metamorphosis" of cord cells, periportal infiltration with neutrophils and lymphocytes, moderate to marked intralobular bile ductule proliferation, and "acinar" formation of cord cells about bile "plugs." Both bile and hemosiderin pigment were seen in modest quantities in cells and portal areas.

Lungs appeared airless and collapsed. Congestion was marked and septal capillaries were filled with neutrophils. Alveolar spaces were filled with varying numbers of red blood cells, "septal" cells, macrophages, and debris.

Red cell galactose-1-phosphate uridyl transferase levels were 0 (normal is 1.7-9 $\mu$/Gm. of hemoglobin). Urine galactose was found in a concentration of 5 mg./ml. Enzyme levels in family members were: Mother—5.5 $\mu$; Galactosemic sib—0; Well sib—4.2 $\mu$ (female); Newborn sib—3.2 $\mu$ (cord blood).

## Comment

While morphological alterations in the liver of older survivors of galactosemia may be characteristic,[9] those patients dying with galactosemia during the first two weeks of life have only massive fatty metamorphosis in their livers (Fig. 2). The peculiar pattern observed is suggestive of galactosemia but by no means specific at this age. Rarely, foci of necrosis and bile stasis are seen early, but these findings, together with "pseudoacinar" arrangements of cord cells about bile plugs and varying degrees of hepatic fibrosis, are more characteristic of a later stage in the disease (Fig. 3). A Laennec-type cirrhosis may be one of the end results of untreated galactosemia. A number of cases of death in early infancy, morphologically characterized only by massive hepatic fatty metamorphosis, may be undiagnosed instances of this disease. It is possible that galactosemia may also act to potentiate the effects of transplacental serum hepatitis (neonatal or giant cell hepatitis), acting in a similar manner as such congenital liver diseases as erythroblastosis fetalis and extrahepatic biliary atresia.

The effect of treatment upon the morphology of the liver is not known, but treatment does not always prevent death in the neonatal period. It is possible that these cases are genetically different from classical galactosemia and equally possible that the infants have already been infected with an organism that thrives in a galactose-rich medium. It is suggested that all infants born in a family in which there is a history of galactosemia should be placed at birth on a galactose-free diet and treated prophylactically for sepsis until the disease can be diagnosed or ruled out by measurement of galactose-1-phosphate uridyl transferase activity.


## SUMMARY

Congenital galactosemia is an inherited metabolic disorder which can be detected at birth and which can be treated by rigid exclusion of galactose from the diet. A specific diagnostic test for the disease is available and the diagnosis can be made using cord blood. Effective treatment requires careful attention to the diet. All infants born in a family in which there is a history of galactosemia should be placed at birth on a galactose-free diet and treated prophylactically for sepsis until the disease can be diagnosed or ruled out by measurement of galactose-1-phosphate uridyl transferase activity. A clinical report is presented of a galactosemic infant who died of sepsis at age two weeks.


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PHENYLKETONURIA.—Observations on the effect of termination of a phenylalanine-restricted diet at 4 years of age are reported on three children with phenylketonuria treated from earliest infancy. No deterioration of their satisfactory mental development has been noted during the subsequent two and a half years, one and a half years, and two months, respectively. — Frederick A. Horner, M. D., et al.: *The New England Journal of Medicine,* 266:79-81, January 11, 1962.

# Classification of Leprosy for Its Management and Prognosis*

JESÚS TRUJILLO VALENCIA, M. D.

IN THIS now small world, the problem of the diagnosis of leprosy may arise anywhere, even in Ohio. Patients whose leprosy initiated and developed elsewhere have been observed in Ohio. It is necessary that all physicians know about leprosy. Unfortunately, for most, their knowledge is scanty and their unwarranted prejudices still great.

The classification of leprosy is important for an understanding of the clinical types, their progress and prognosis. Leprologists in Brazil, Mexico, and Argentina have developed and contributed brilliantly to the present dynamic classification of leprosy.

### General Aspects

The disease, Leprosy (Hansen's Disease), the origin of which is lost in the obscurity of bygone ages, and which for centuries had been considered as confused, mysterious, contagious, and absolutely incurable, has been beating a slow but definite retreat in our times.

In reality, there was good reason to think that leprosy was confused, protean in appearances, and multifaceted, since the manifestations are so varied. The veil of mystery in which leprosy has been enveloped was woven from medieval prejudices whence arose leprophobia. There is shameful recollection of the ceremonies in which the diseased were declared excluded from daily life and commerce, and it was a true living death when they were locked up in leprosaria. Nor as yet are the other atrocities forgotten such as the custom of stoning the afflicted or causing them to bear signs or to carry lanterns to announce their presence. Our ultimate shame is in the deaths caused by the application of certain wretched restrictions.

Although there is widespread belief, even within the medical profession, that leprosy is extremely contagious, it can be said that this is the least contagious of the infectious diseases. Intimate and prolonged contact with a malignant or lepromatous patient is necessary for even the possibility of contracting the disease. Moreover, it is not congenital, and there is even a natural defense or resistance to it. Relative to the point of the absolute incurability of leprosy, we have had the privilege of being present at the chemotherapeutic miracle of the slow healing of the lepers, when they were given the drug diamino-di-phenyl-sulfone, a medication which was first employed against the tubercle bacillus and certain strains of staphylococcus.

*Address given as part of the Graduate Course in Tropical Dermatology for the Department of Dermatology, The University of Cincinnati College of Medicine, 1961.
Edited with the assistance of Dr. Leon Goldman, Professor of Dermatology, The University of Cincinnati, Cincinnati, Ohio.

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### Distribution of Leprosy in the World And in Mexico

Leprosy is encountered in all climates and latitudes, but predominantly in humid and hot locales. In Mexico its distribution is influenced by historical, social, and economic factors. The four centuries that we have suffered from this disease have not been sufficient for it to migrate to favorable climates. The Spanish conquistadores brought the disease to our country and later the boats from China and commerce with the Orient enriched us with new foci of infection.

As improvements in means of transport were made in areas relatively free of the disease, more cases of Hansen's disease were seen. The lack of hygiene and adequate diet must have favored its diffusion.

### Actual Classification

The classification of Madrid of the year 1953 (Sixth International Congress) has simplified the clinical understanding of leprosy. There are, in brief, two basic types, viz.: malignant or lepromatous, on the one hand, extreme tuberculoid on the other, and two groups indeterminate and dimorphic in between.

Type "L" Lepromatous Maligna

| | |
|---|---|
| Group "I" | Group "D" |
| (Indeterminate cases) | (Dimorphic cases) |
| | Wade's Borderline |

Type "T" (Tuberculoid, benign)

The fundamental characteristics of *type "L"* are its lepromatous structure, the lack of resistance, many

bacilli, ready transmissibility, and progressive deterioration. The clinical types may be diffuse, infiltrative or nodular.

*The tuberculoid type "T"* is characterized by the tuberculoid structure, resistance, lack of transmissibility, and its tendecy to spontaneous healing. The clinical types are reacting form and the fixed form. Latapi, in Mexico, has emphasized the value of considering these details.

In the scheme of classification we see two in-between groups of cases, viz.: indeterminate and borderline (dimorphic). The *indeterminate* cases are those which at the time of study cannot be classified either as "L" or as "T" type. They are characterized by hypopigmented spots and neuritis; they can evolve toward either pole of classification.

The cases of the *"border-line group"* are malignant, very rare, and are actually considered as "L" cases with a tuberculoid mask or facade. Their group is considered as a collection of cases with less definite common characteristics, less stability, or uncertain evolution.

### Basis of Classification

1. *Histopathology* constitutes one of the fundamental bases of the classification. Three different processes can be encountered in leprosy: the lepromatous granuloma, the tuberculoid granuloma, and the non-characteristic inflammation of the indeterminate cases. The lepromatous structure is typical. It is characterized by epithelium thinned even to a hyaline band with nodules of infiltration, vaculated foamy Virchow cells in which it is possible by means of stain to demonstrate very numerous single bacilli and also accumulations of bacilli in clusters.

In tuberculoid leprosy, the histopathologic structure resembles the tuberculous follicle. There are sharply isolated follicles with zones of lymphocytes and plasmacytes at the periphery, and in the center epitheloid cells and typical Langhans giant cells. In general, there is an absence of Hansen's bacilli.

In the Indeterminate Group, the histopathologic structure is that of simple inflammation.

2. *Immunobiology.* Immunobiologic tests were developed by Mitsuda. In his honor the reaction is called the Mitsuda reaction. Fumio-Hayashi introduced secondary modifications; therefore, the name "intradermal reaction of Mitsuda-Hayashi" is also employed. You call it the lepromin test, or the lepromin reaction. It is a crude type of reaction. The material is always prepared from tissue rich in bacilli and cellular debris. There are three varieties of lepromin: integral, purely bacillar, and protein. The test is performed by injecting intradermally into healthy skin one-tenth of a cubic centimeter of lepromin.

*Time of reading.* All authors are in agreement that the reaction ought to be read at the third week, observing in the positive cases a nodular induration of one-half centimeter or more, which can ulcerate and eventuate in a plainly visible sharply demarcated

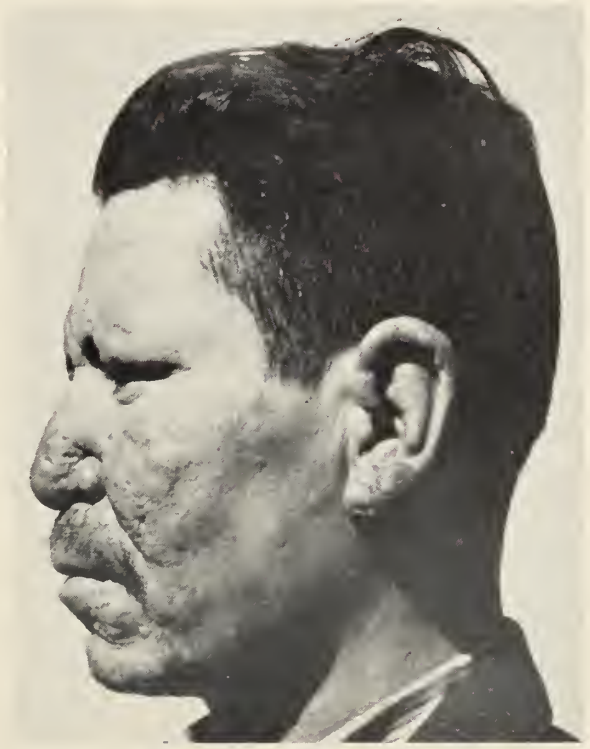


FIG. 1. *Leprosy—Lepromatous—nodular type. Note characteristic ear involvement and loss of eyebrows.*

scar. On the contrary, in the negative cases, there is no residual trace of the injection.

The investigations of Fernandez from Argentina, have demonstrated that the reaction is already definite clinically and histologically in 48 hours. In the positive cases there is an erythematous halo more than 1 centimeter in diameter, increasing on occasion to 6 or 8 centimeters, and this can persist several days. The two types of responses, early and late, are not always in agreement.

*Significance.* The positive intradermal reaction indicates allergy and resistance, wherefore it is positive in the tuberculoid cases, negative in the lepromatous cases, and variable in the indeterminate cases. Therefore, we find positive results in normal individuals from endemic zones (primary infection, lepra infection, but not the disease of leprosy); negative results in some contacts and inhabitants of endemic zones (lack of protection) or, naturally negative in healthy persons from endemic spots (anergy through lack of exposure).

*"Medina's Reaction"* (Mexican). The lepromin reaction, in advanced cases of lepromatous leprosy with the phenomenon of Lucio, many times gives a response even more accelerated, in four to six hours, an isomorphic response. That is to say, the aspect of the phenomenon of Lucio is reproduced. The same is obtained employing other antigens, streptococcal, staphylococcal, Frei, etc.

3. *Bacilli.* The Leprosy Bacillus, discovered by Gerard Armand Hansen in the year 1868, is classified taxonomically among the lower fungi *(Myco-*

*bacterium leprae).* Its isolation and cultivation still have not been acomplished and constitute a challenge for bacteriologists.

The search for the bacillus ought to be performed rountinely from material obtained by scraping the nasal mucous membrane, preferably from the septum, and not from the nasal secretions. In the case of skin lesions, a small incision is made and the edges are scraped. Lymph nodes can be punctured or excised. Staining is carried out using the method of Ziehl-Neilsen. In lepromatous patients when adequate technique is followed, positive results are always obtained. In tuberculoid leprosy, bacilloscopy of the skin and nasal mucous membranes is almost always negative. In the group of indeterminate cases, the bacteriologic findings in the nasal mucous membrane are negative, and the persisting presence of bacilli signals its mutation into the lepromatous type, even when we find no other clinical manifestations. In the cutaneous lesions, bacilloscopy is negative. When the results are positive, it also indicates a change toward the malignant pole of the classification.



FIG. 2. *Leprosy—Lepromatous—nodular type.*



FIG. 3. *Leprosy—Lepromatous—Lucio phenomenon.*



FIG. 4. *Leprosy—Tuberculoid Reactive.*



FIG. 5. *Leprosy—Tuberculoid Fixed—5 year old girl; mother had lepromatous leprosy.*

4. *Serology.* There are no specific serologic tests for leprosy at present. Experience has shown that patients with lepromatous leprosy showed positive serologic test for syphilis. Such serologic tests are negative in tuberculoid leprosy; may or may not be positive in the uncharacteristic type for leprosy. Just as today the biologic false positive serologic test for syphilis in a young individual often suggests diseases like lupus erythematosus, so such biologic false positive tests can occur in leprosy.

5. *Erythrocyte Sedimentation.* As we know, there are physiologic, pathologic and technical causes which increase the velocity of cellular sedimentation, wherefore, this study has only a relative value. Higher figures are obtained in lepromatous leprosy. In the lepromatous patients an increase in sedimentation rate heralds the appearance of an acute Lepra reaction.

6. *Clinical.* The most important clinical characteristics of the lepromatous type are: generalized nodules, diffuse infiltrations; alopecia of the eyebrows and eyelashes; lepromatous neuritis, visceral

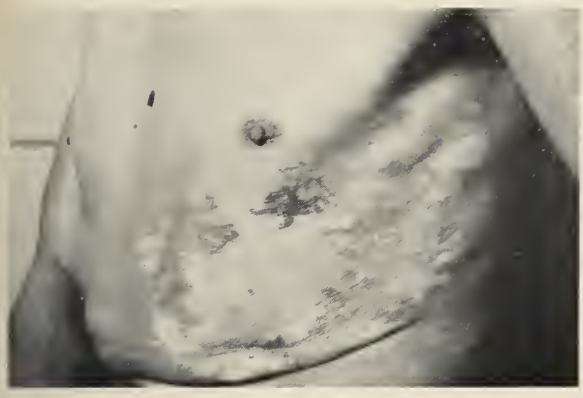


FIG. 6. *Leprosy—Indeterminate.*

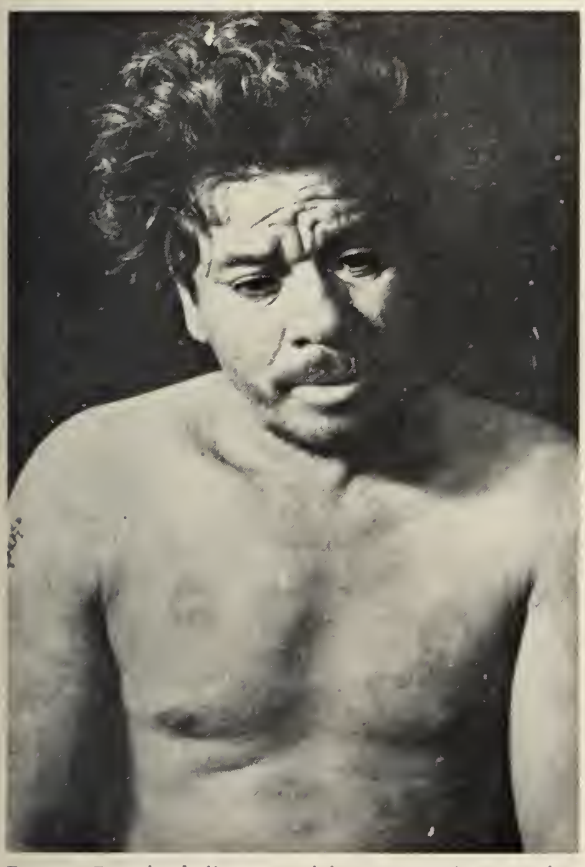


FIG. 7. *Rare borderline case of leprosy. Lesions on chest have a tuberculoid appearance but other features indicate a lepromatous type.*

complaints; ocular difficulties; acute febrile reactions and bacilliferous rhinitis. In the tuberculoid type: peculiar dermatoses of erythematous spots with sharp borders; neuritis; absence of visceral complaints; absence of ocular complaints; no febrile reactions; and no Hansensian rhinitis. In the indeterminate group: hypopigmented spots, neuritis, and visceral and ocular integrity without rhinitis and febrile reactions.

7. *Prognosis.* The lepromatous types have a poor prognosis; the tuberculoids have a good prognosis. That of the indeterminates is uncertain. Dimorphic cases are considered as lepromatous.

8. *Development.* Types "L" and "T" which represent the poles of the classification are considered as stable and fixed, while group "I" is characterized by instability and a tendency to develop into one or the other stable types.

9. *Public Health.* The lepromatous patient constitutes a public health problem because of the infectious nature of his disease; tuberculoid leprosy is not contagious, but it does serve as a clue in discovering an antecedent lepromatous focus; and the Indeterminates are not infectious as long as they do not undergo "lepromatization."

10. *Therapeutic.* Before the era of the sulfones, we said that the malignant lepromatous type was incurable. Now we can say that there is slow healing while the medication is administered. In the benign type, the tuberculoid healing is spontaneous. In the indeterminate group there are certain rare cases (quiescent) which stop in their evolution without treatment. The usual thing is for them to undergo a motivation toward one of the opposite poles of the classification.

One milligram of sulfone per 100 cc. of blood is considered to be the optimum blood level to produce a good therapeutic result. In the beginning, there was a fear of the parent sulfone because of its tendency to produce hemolytic anemia. This fear has been lost as smaller doses have been used. The doses first employed by the oral route were from 200 to 300 milligrams a day. Now these have been reduced to 25 to 100 milligrams as a maximum, and this dose is further reduced in those cases which show the acute lepra reaction, in which the synthetic antimalarials and small blood transfusions are now employed with good results.

In Ohio, you may find cases in individuals coming from endemic areas. You may find cases in individuals who have served in the Armed Forces previously stationed in endemic areas. Therefore, maintain a high index of suspicion when you work in Veterans Hospitals. Above all, be tolerant and understanding in your attitude to the rare case you may observe.

In conclusion, we ought to recognize the merit in the classification to Jadassohn who was first to show the importance of the structural difference of the diseased tissue in the relationship with the types of the diseases; to the authors of the scheme of Manila and of Cairo who distinguished between the malignant and the benign type; to the prominent Brazilian dermatologists, above all, Rebello, Jr., who in 1938 with his concept of the polar types resolved one of the most complicated problems.

We must agree with Latapi that if any exceptional case departs from the norms of the classification, we are not going to destroy the concept of the polar types. Just as the classification of the human race into the male and female sexes has not been modified by the existence of gynecoid males and android females. We must not forget that we are moving over a biological terrain which lacks much of mathematical certainty.

# A New, Superior Vehicle for Topical Dermatologic Therapy

IRVING L. SCHONBERG, M. D., JEROME Z. LITT, M. D., ALFRED BROTMAN, M. D., and ALVIN M. LASHINSKY, M. D.

IT IS well known that the properties of a topical medicament are significantly influenced by the base in which it is incorporated. Some ingredients are more active when incorporated in water miscible creams, others in ointments, and still others in pastes. Not only may the vehicle influence the penetration of the active agent into the skin, but it may exert by itself either a beneficial or an adverse effect upon the course of the skin eruption.

The purpose of this paper is to report on a recently devised base, called Cebum® Cream*, which appears to augment the excellent activity of hydrocortisone alcohol when this steroid is incorporated in this vehicle.

## Discussion

Because of the important role played by the vehicle in determining the effectiveness of the incorporated agents, pharmaceutical firms have devoted much research to finding the "ideal base." Such a base should be nonirritating, should allow the maximum amount of penetration of the active agent from the base into the skin, should not dry out the skin by dissolving the natural sebaceous material from it, should allow for the escape of heat from inflammatory processes and of serous discharge from oozing or infected lesions, and should have a very low index of sensitivity. In short, this base should have characteristics which approach those of the natural secretions of the skin, which is essentially an emulsion of sweat and sebum. Not only does this emulsion act to lubricate the skin and keep it supple, but because of its bacteriostatic and fungistatic properties, appears also to protect the skin from infection.

Peck,[1,2] Keeney,[3,4] Theodore,[5,6] and others have observed that fatty acids found in sweat have fungicidal and bactericidal properties. Since these substances must be present in proper concentration to exert a fungistatic or fungicidal effect, it is readily understandable that when sweat is alkaline, it will be less fungistatic or bacteriostatic. As described by Peck,[7] "It is the constituents of the sweat which played the chief role in the protective cloak on the skin surfaces against both bacteria and fungi. We were able to demonstrate that a number of the lower fatty acids in the sweat were fungistatic as well as bacteriostatic. It was not the pH *per se* that was important but the factors that go into the formation of the pH value which render the acid cloak a protective film against infection."

The self-sterilizing power of the normal skin is influenced not only by the sweat gland secretions, but also by the exudations of the sebaceous glands. Pillsbury and Kligman[8] summarized this aspect by stating, "The rapid disappearance of *Streptococcus pyogenes* is probably due, at least in part, to the chemical sterilizing effect of fatty acids contained in sebum, particularly the unsaturated fraction."

Thus, artificial sebum, emulsified with artificial perspiration, should provide a unique acid-mantle type cream which could be an almost natural lubricant of the skin and also would be an effective vehicle for penetration of active ingredients into the skin because it would mix completely with the natural skin secretions. Furthermore, it would act to replen-


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*Manufactured by Dermik Pharmacal Co., Syosset, N. Y.

ish the natural secretions of diseased or aged skin and could perform bacteriostatic and fungistatic functions.

The artificial secretion of the sweat glands as approximated by Peck[7] and his associates consists of:

| | | |
|---|---|---|
| Water | 99.02 | % |
| Acetic Acid | 0.00096 | % |
| Caprylic Acid | 0.0046 | % |
| Sodium Chloride | 0.700 | % |
| Lactic Acid | 0.100 | % |
| Citric Acid | 0.010 | % |
| Ascorbic Acid | 0.004 | % |
| Urea | Trace | |
| Uric Acid | Trace | |

Synethetic sebum similar in composition to the natural as described by Wheatley, MacKenna and Wormall[9,10,11] can be approximated by the blending of certain vegetable oils in proper proportion. The normal sebum was analyzed as follows:

| | |
|---|---|
| Free fatty acids (saturated) | 14.34% |
| Free fatty acids (unsaturated) | 14.04% |
| Tryglycerides | 32.5 % |
| Waxes | 14.0 % |
| Free cholesterol | 2.0 % |
| Cholesterol esters | 2.1 % |
| Other sterols | 0.4 % |
| Squalene | 5.5 % |
| Paraffins (branched chains) | 8.1 % |
| C18 to C24 Alkane-diols | 2.0 % |
| Unspecified | 5.1 % |

In imitation of the natural aqueous and oily secretions of the normal cutaneous surface, a pure white emulsion was recently developed with the outer aqueous phase made up of artificial perspiration and the inner oily phase consisting of synthetic sebum (Cebum Cream). This vehicle, whose constituents simulate the normal surface secretions of human skin, induces rehydration, softens the stratum corneum and appears to eliminate the physical phenomena characteristic of vanishing creams such as dryness and irritation. The objectionable occlusive greasiness and defatting action of petrolatum type ointments is avoided. It has a pH of 5.5.

In addition, this preparation has been remarkable in that there have been virtually no side effects such as sensitivity, irritation, burning sensation, or any other untoward, undesirable side effects, even when employed in patients with a predisposition to allergic manifestations.

Because of the unusual nature of this cream, it was clinically investigated for efficacy with hydrocortisone as its active ingredient. This product is available as Hytone® Cream.*

## Materials, Methods and Results

One hundred and seventy-six patients with a variety of skin eruptions were evaluated using a double blind study and the simultaneous paired comparison method. The Hytone Cream, a 0.5 per cent colloidal solution of hydrocortisone in Cebum Cream, was compared to a 1 per cent micronized suspension of hydrocortisone in hydrophilic petrolatum.** Both products were prepared and labeled in such a way that neither the patient nor the physician knew the identity of the products being tested. Patients were selected who had lesions that were usually responsive to topical hydrocortisone therapy and whose lesions were present on bilateral sites of their bodies. They were evaluated for subjective response as well as for objective changes after using the ointment for periods from 24 hours to two months. The results are shown in Table 1.

As can be seen in the table, in 111 out of the 176 patients, the 0.5 per cent Hytone cream was as effective as the 1 per cent hydrocortisone in petrolatum base preparation in producing objective improvement. In 38 out of the 176 patients, the 0.5 per cent Hytone cream was superior to the 1 per cent hydrocortisone preparation. In 27 cases, the 1 per cent hydrocortisone ointment was better than the 0.5 per cent Hytone cream. Subjectively, in those patients in whom the Hytone cream and the 1 per cent hydrocortisone ointment were judged equally effective, most of these patients preferred the 0.5 per cent Hytone cream because it seemed to be much less oily and gave them a cooling sensation rather than the warmth that seemed to be engendered by the ointment containing hydrocortisone.

In addition to these patients, the 0.5 per cent Hy-

TABLE 1.

| Type of Disease | Number of Patients | OBJECTIVE IMPROVEMENT | | |
|---|---|---|---|---|
| | | 0.5% Hytone Cream more effective than 1% hydrocortisone in petrolatum base | 0.5% Hytone Cream as effective as 1% hydrocortisone in petrolatum base | 0.5% Hytone Cream less effective than 1% hydrocortisone in petrolatum base |
| Atopic Dermatitis | 67 | 9 | 47 | 11 |
| Contact Dermatitis | 44 | 11 | 27 | 6 |
| Seborrheic Dermatitis | 19 | 5 | 11 | 3 |
| Hand Eczemas | 20 | 8 | 9 | 3 |
| Nummular eczema | 9 | 1 | 7 | 1 |
| Stasis Dermatitis | 7 | 1 | 4 | 2 |
| Intertrigo | 5 | 2 | 3 | 0 |
| Pruritic Psoriasis | 3 | 1 | 1 | 1 |
| Lichen Planus | 2 | .... | 2 | .... |
| Totals | 176 | 38 | 111 | 27 |

*Manufactured by Dermik Pharmacal Co., Syosset, N. Y.

**Supplied by Dermik Pharmacal Co., Syosset, N. Y.

tone cream was also studied in well over 100 other patients with eruptions usually responsive to topical steroid therapy. These included patients with acute and chronic contact dermatitis, vesicular and scaly hand eruptions, pruritus, and many other conditions. The preparation was almost universally acceptable to patients because it was cooling, easily rubbed into the skin, and not greasy. The Hytone cream would often improve the appearance of the lesions within 24 hours, while relieving the pruitis within a few hours. In all patients studied, not one instance of allergic sensitization or irritation from the Hytone cream was noted.

## Summary

A new vehicle, closely simulating natural skin secretions, is herein reported as well as its therapeutic efficacy when employed in steroid therapy. This product was found to be nonirritating, nonsensitizing, and cosmetically acceptable to patients. Clinically, it appeared to enhance the effectiveness of the hydrocortisone that had been incorporated in it, as compared to the hydrocortisone in a petrolatum base.

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**TOLBUTAMIDE IN MULTIPLE SCLEROSIS.** — The results of this controlled trial in 40 patients with multiple sclerosis gave no basis for the use of tolbutamide to treat this disease.

A restricted randomization scheme was used to insure 2 comparable groups of patients, after which 1 group was treated with 500 mg. of tolbutamide three times daily and the other was given placebo tablets. Which patients were receiving tolbutamide was not known to the physician who examined them at the beginning of the trial, after 28 days of treatment, and at three months.

The patient's impression of his improvement or deterioration showed very little correlation with the change in Alexander score for severity. With this method of scoring, a positive change shows deterioration and a negative change indicates improvement. The results were as follows:

| | Tolbutamide | | Placebo | |
|---|---|---|---|---|
| | 1 mo. | 3 mo. | 1 mo. | 3 mo. |
| Average change in Alexander score | +6.05 (±9.0) | +0.05 (±9.6) | −0.90 (±8.1) | −6.55 (±4.6) |
| Patients' assessment: | | | | |
| Better | 4 | 4 | 3 | 2 |
| Unchanged | 10 | 10 | 11 | 11 |
| Worse | 6 | 5 | 6 | 8 |

The apparent benefit from placebo treatment was not statistically significant. The range of response was wider in the tolbutamide group, which contained the two best and the two worst responses to treatment; this finding seems to be of no biological significance. — J. B. Foster, D. J. Newell, Henry Miller et al., Newcastle upon Tyne, (England): ABSTRACT: Lancet, I:915-917 (April 29) 1961.

# Sphaceloderma

## A Report of an Unusual Case with Postmortem Examination

DAN J. KINDEL, M.D., and LAWRENCE C. GOLDBERG, M.D.

SPHACELODERMA is an ancient but intriguing name which invites the curiosity of the reader and appals the imagination of the observer. It is translated into an unusual but not rare condition that spells gangrene of the skin. The paucity of its appearance in the literature gives us the impetus for this report on this morbid dermatosis.

Sachs[1] reviewed the literature on sphaceloderma from the original classification by Crocker to his own report written in 1936. Except for an occasional reference, the name sphaceloderma then disappeared from the literature, but was again alluded to by Sachs while discussing a case of gangrene of the skin secondary to menigococcemia presented by Katz[2] at the Manhattan Dermatological Society meeting in November, 1958. Sachs' original case was one of extensive ulceration of spontaneous origin in a girl 10 years of age, who had no associated subjective or constitutional symptoms. It started without cause and terminated after four years without apparent cause.

### Reported Etiological Factors

It is believed that this dermatosis is caused by circulatory disturbances, infection, acute inflammatory disease (such as the acute examthemata, typhoid fever, malaria, erythema multiforme, etc.), chronic disease (such as tuberculosis, syphilis, diabetes, etc.), trophoneurosis (such as Reynaud's Disease, Buerger's Disease, syringomyelia, etc.), drugs such as aminopyrine reported by Buchanan,[3] trauma, Schwartzman reaction, and unclassified or idiopathic as reported by Turquety[4] and Swarts.[5] These two authors state that acute idiopathic gangrene may appear spontaneously in healthy persons. The lesions start as small vesicles, and the area quickly becomes black and enlarges to a gangrenous plaque. Physical, neurological and laboratory studies are negative. The condition heals in about six to eight weeks leaving a smooth scar.

Blatt[6] et al. reported a case of dermatitis gangrenosum infantum. This was secondary to varicella, but it can be a complication of other exanthemata. In these cases, there is probably a Schwartzman reaction (this may also be true of pyoderma gangrenosum) that produces the gangrene of the skin and subsequent contact with the sensitizing antigen which produces the gangrene in the sensitized areas. The younger the child, the more serious the prognosis. In some of these cases hemolytic staphylococcus aureus is sometimes cultured from the lesions and the blood stream. Bernstein[7] and Goldberger presented a case of multiple sphaceloderma of the leg associated with generalized amyloidosis. These lesions were also thought to be caused by acute arteritis. Woolridge[8] et al. and Toraine[9] et al. described gangrenous plaques of the skin, which were associated with infection and usually followed some minor injury. This type of gangrene is often associated with staphylococcus, streptococcus, colon bacillus, and bacillus proteus. Occasionally it is secondary to a Meleney ulcer and produces Meleney's progressive bacterial synergistic gangrene.

### Characteristics of Gangrene

The lesions in the case which we report started as a pink macular and purpuric area on the glabrous skin. This quickly became bullous and within a few days was gangrenous. The gangrene extended deeply into the fat and subcutaneous tissue producing large blocks of black eschar. When some of this material separated from the underlying tissue, large, gaping, ulcerating and suppurating areas were noted. This sloughing con-


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Submitted September 15, 1961.

tinued until some of the lesions became as large as the palm of the hand, and more than an inch deep.

None of the previously reported cases which we have studied appeared to be similar to the present case as to extent, severity, bizarreness, or cause as disclosed by postmortem findings. As a matter of fact, none of the reported cases which we examined have had postmortem study. This case was definitely caused by an obstruction of the circulation by thrombi within large blood vessels. According to Crocker, as reviewed by Sachs, this is the most common cause of sphaceloderma. We also believe that this is the oldest patient on record, and the attendant malignancy which was discovered by the postmortem examination played no role in the production of this dermatosis.

## Case Report

The patient, an Episcopal Nun, was first seen in August 1960 at the request of the family doctor, who thought she had pemphigus. The past history indicates that the patient had always been well, apparently healthy, and of unusual vigor for her 84 years of age. She had been in the convent for approximately 40 years.

In March 1960, she first complained of her feet bothering her when she would walk, and she frequently sat down, sometimes on the floor, to secure comfort and freedom from tenderness and pain. Otherwise, there was no history of pain or discomfort. This continued for about a month until bullae occurred on the heels, and she was sent to the infirmary, where she was treated by wet soaks of Epsom salts. At this time she had "blisters" on her heels, and



FIG. 1. *Extensive areas of deep gangrene indicating predilection for pressure areas of back, trochanters, and heels but similar lesions occurred on internal aspects of thighs, vulva, and pubis.*



FIG. 2. *Large area of gangrene with subcutaneous fat exposed at edges and black leathery dry slough in process of separation.*



FIG. 3. *Deep lesion on left thigh; black crust has separated.*

these were punctured and healed with the Epsom salts soaks. Two weeks after her admission to the infirmary, she developed a large bulla on the left thigh which became more red and indurated than any previous lesions on the heels.

Shortly thereafter, during the latter part of April 1960, new bullae began appearing in other areas of the body but at no time did she have any lesions on the face, neck, scalp, forearms and upper arms. The blisters went through a cycle of about three to four weeks with the induration continuing and then resulting in a black, irregularly shaped, leathery escharotic crust which within another week or two separated at the edges and exuded yellowish purulent material in great quantities. Removal of the crust revealed deeply destructive lesions extending down to the muscle, with complete necrosis of everything between the surface of the skin and the muscle.

There was no mechanical or thermal insult to any of the tissues at any time as far as could be determined nor had any heat been applied in the form of hot water bags or electric pads.

There was a tendency for the lesions to show up most on the pressure points of the hips, thighs, knees and back, but severe lesions were also noticed on the internal aspect of both thighs extending up to the vulva. In this area pressure or trauma could not be a factor.

There were no lesions on the toes although the lateral aspect of the foot and heels were extensively involved. A urinalysis done by the family doctor was stated to be negative, and a blood count also showed no changes. These were done sometime between April and August.

At the time the patient was first seen, she was well nourished and well developed but was moribund and could not be aroused. She had had excellent nursing care and

supervision and had received some injections of penicillin but no other therapy.

The patient's condition seemed hopeless, and it appeared that she might not last through a 24 hour period. No therapy was given, and the patient died approximately one week after she was first seen. A postmortem examination was completed.

## Autopsy Findings

"The skin over the thorax contains numerous petechiae and small areas of purpura. The skin of the lower half of the body shows extensive areas of gangrene. For the most part these are superficial and show dry mumification of the skin. One of the large areas on the left buttock, however, is excavated and ulcerated down to the level of the fascia. This measures about 6 by 8 cm. Other areas are found in both inguinal regions, on the anterior aspect of the left thigh, the medial aspect of the right thigh, both buttocks, the right popliteal area, medial aspect of the right knee and right leg, the medial aspect of the left knee and the medial aspect of the right heel. Sections are taken of the cutaneous petechiae in the chest, of any early mumifying lesion in the suprapubic region, and of the large ulcerated lesion in the left buttock.

"In the abdominal segment of the aorta there is a fusiform dilation to a maximum diameter of 5 cm. About two thirds of the lumen of this aneurysm is occluded by a laminated pale yellow thrombus.

"The thoracic and abdominal segments of the aorta contain numerous yellow atheromatous plaques, and there is extensive calcification of the abdominal segment. The major branches of the aorta are patent with the exception of the celiac axis. This vessel is completely occluded by a laminated pink, dry thrombus. The large veins are normally distributed, thin walled and patent.

"The lungs weigh 540 grams and 420 grams, right and left respectively. Each of the main pulmonary arteries is partially occluded by a plaque of laminated, dry, granular, pink thrombus. None of the pulmonary branches are occluded by these thrombi.

"The digestive tract shows no significant abnormalities in the mucosa, wall or serosa, from the mid-esophagus to the sigmoid colon. In the midportion of the sigmoid there is an oval tumor involving about two thirds of the circumference of the lining. It measures 3 by 4 cm. The base is ulcerated and the edges are elevated, red and granular. The tumor extends through the muscularis, but it does not show significant penetration of the adjacent fat, and there is no gross evidence of metastatic involvement of the nodes.

**Final Diagnosis:** (1) Carcinoma of sigmoid colon. (2) Thromboses of pulmonary arteries and celiac axis, thrombosed arteriosclerotic aneurysm of abdominal aorta. (3) Extensive dermatitis gangrenosum. (4) Vascular nephrosclerosis. (5) Slight pulmonary edema, healed pulmonary tuberculosis."

Dr. Daniel Richfield gives the following report on three sections of the skin taken at the time of the autopsy:

## Histopathology

By Daniel Richfield, M. D.

"Sections from the buttocks at the edge of a necrotizing ulcer show a deep infiltrate of neutrophils and histiocytes. Very prominent is a dilatation of the lymphatics and capillaries in the superficial dermis with no changes in the deep vessels on this section (not usually present). A section from the suprapubic lesion showing dry gangrene grossly, a small muscular artery in the subcutaneous fat shows no changes whatsoever. Incipient early lesion from the posterior shoulder shows only a dilatation of superficial capillaries."

## Conclusion

An unusual and bizarre case of sphaceloderma in an 83 year old nun is reported. Insofar as we know, this is the oldest patient to have had this disease and the only one whose report contains a postmortem examination. It was caused by thrombi within large vessel walls which were found to be atheromatous. Inasmuch as the patient was seen in coma, and death was imminent, no treatment was given. This entity should not be confused with pyoderma gangrenosum.

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ENERGY TRANSFORMATION IN THE CELL. — The past few years have seen great advances in the investigation of the transformation of energy by the cell. In its present stage our understanding encompasses not only some of the chemical and physical aspects of the process, but has begun to take in the arrangement of the molecules in the cell that conduct it. Many of the active molecules, the enzymes, have been identified. The intricate chains and cycles of activity by which they extract, trap, exchange and distribute energy have been worked out in sufficient detail to illuminate their principles of operation. And the molecular machinery of these energy-transforming functions has been securely located in the mitochondria, structures found in all cells that burn their fuel in oxygen.

This paper discusses the process by which the living cell converts the energy of foodstuff into a form that can be utilized and stored. — A. L. Lehninger: *Scientific American,* 202/5:102-114 (May 1960).

# Aberrant Annular Pancreas

## With Report of a Case

KIRK KALEMKERIS, M.D.

ANNULAR PANCREAS is a rare anatomic curiosity. It is a congenital anomaly of the ventral anlage of the pancreas, developing independently and coming to surround the descending duodenum as a circular or hemicircular or, at times, constricting band. The annular pancreas preserves continuity with the pancreas proper.

Pancreatic rests, however, are not uncommon in the small intestine. They are defined as pancreatic tissue outside its usual location and having no anatomic relation either of continuity or of vascularization with the pancreas proper.

### Morphology and Histology

*Pancreatic Rest:* On section of a pancreatic rest the tissue is grayish white with irregular patches of some denser tissue. Microscopically it resembles normal pancreatic tissue with ducts and acini and occasional islands of Langerhans.[1] They range from a few millimeters to 4 or 5 cm. in diameter. The most common site of these aberrant pancreatic nodules is in the second portion of the duodenum; the next most common is in diverticula of the small intestine, such as Meckel's diverticulum. It has even been suggested that these displaced pancreatic cells might be the causative agents in the formation of the diverticula. In more than one half of the cases, the nodules of pancreatic tissue are imbedded in the submucosa, in other instances in the muscularis, and, least commonly, they are either subserosal or involve all layers of the intestinal wall.

On a histologic basis, Derbyshire divided these into three classes. In the first class were placed those nodules which essentially resemble normal pancreas in the arrangement of their lobules, acini, and ducts. In class two the lobules are imperfectly formed or no lobular arrangement is seen, the acini are not numerous and there is a large number of ducts. In the third class, only ducts are present. There seems to be a close relationship between Derbyshire's third class and the adenomyoma as described by other authors. Taylor says, "It is impossible to draw a precise line of distinction on histological grounds between the adenomyoma and accessory pancreas for the former often includes a portion of pancreatic tissue showing imperfect differentiation, while the latter in most cases contain duct spaces far in excess of its requirements, and not infrequently shows unstriated muscle fibers in its stroma." Lauche (1924), cited by Taylor, gave to adenomyomas the name of *incompletely differentiated accessory pancreas.* In 1940 Clarke suggested the term *myoepithelial hamartoma* to cover all such masses of developmental origin.[2]

Submitted May 18, 1961.

*The Author*

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*Annular Pancreas:* Annular pancreas denotes a formation of pancreatic tissue which forms a "ring around the second portion of the duodenum and preserves continuity with the pancreas proper."[4] It is not necessary for the aberrant tissue to form a complete ring. The important thing is that the aberrant tissue and the pancreas are connected by a duct. The duct of the annular tissue arises anteriorly and courses laterally to the right and around the duodenum over its posterior wall terminating in the main pancreatic duct, the common bile duct, or the papilla of Vater. It should not be confused with the so-called heterotopic pancreas, which is a formation of pancreatic tissue entirely independent of the pancreas itself and encountered in the wall of the stomach, duodenum or jejunum, rarely Meckel's diverticulum, omentum, mesentery, splenic capsule, liver and gallbladder, usually with a submucosal localization.[4]

### Embryology and Theories of Origin Of Annular Pancreas

The pancreas originates from a ventral and a dorsal anlage which are provided with independent ducts and closely linked to the intestinal segment destined to become the second duodenal segment. From the dorsal anlage, the tail, the body, and part of the head originate. The ventral one is constituted by two formations located at the sides of the choledochus. Of these, only the right one develops in man subsequently, while the left one atrophies. When the

duodenum undergoes its normal rotation, it takes with it dorsally the ventral anlage and the choledochus, which assumes a dorsal position in close relation to the dorsal anlage completing the formation of the head of the pancreas. It assumes its normal position medially to the second duodenum segment. The duct of the ventral anlage fuses with that of the dorsal one and they both fuse with the choledochus.

Annular pancreas results from a congenital malformation and three hypotheses have been formulated to explain its formation. On the basis of the finding that usually the pancreatic ring has a duct which rises from the medial margin of the second duodenal segment to the lateral margin and continues in the opposite direction astraddle the posterior surface of the duodenum without emptying into the main pancreatic duct, the first hypothesis has been advanced that during duodenal rotation part of the ventral pancreatic anlage remains fixed in its primary position and, developing toward the midline, fuses with the pancreas forming a ring. The second hypothesis attributes the malformation to a persistence of the left ventral pancreatic anlage. This is supported by comparative anatomic studies in birds. The third hypothesis assumes a derivation from hypertrophy of the ventral and dorsal anlages which would terminate in surrounding the duodenum and fuse at the lateral margin of the viscus, but this hypothesis does not explain the presence of a duct in the ring.[4]

## Physiology and Pathology

Practically all authors agree that the aberrant annular pancreatic tissue may be physiologically active. Zymogen granules have been demonstrated in the acinar cells. Also, evidence of islet activity is shown by the recording of several cases of hyperinsulinism and hypoglycemia produced by extra pancreatic insulin producing islet cell adenomas. Pathologically the aberrant or annular pancreas is subject to all the lesions found in the normally placed pancreas. Acute pancreatic edema, acute pancreatitis, cystic fibrosis, and neoplastic change, both malignant and benign, have been found.[2]

## Symptoms

In many cases, annular pancreas is asymptomatic and is discovered incidentally on autopsy. However, enough cases have been reported in which the annular pancreas was producing real and grave pathologic changes to warrant a search for such a lesion whenever the abdomen is opened because of a disease process which is not apparent or is obscure. The clinical symptoms produced by annular pancreas have been misdiagnosed as the following diseases: (1) Pyloric and duodenal obstruction; (2) peptic ulcer classified as (a) chronic, (b) perforated, (c) hemorrhagic or (d) malignant; (3) gallbladder disease; (4) common duct obstruction; (5) pancreatitis; (6) appendicitis, and (7) hypoglycemia.[2]

In rare cases, severe duodenal stenosis required immediate operation soon after birth. In most cases, symptoms appeared during the third to fifth decades of life, probably due to localized pancreatitis, which was demonstrated histologically in 60 per cent of the cases examined. The symptoms include colicky pain in the right upper quadrant and in the epigastrium, anorexia, nausea, and vomiting. The syndrome may simulate that of duodenal ulcer. Clinical examination furnishes no diagnostic information. Roentgenologic examination may demonstrate stenosis of the second duodenal segment. This gives the impression of being caused by constriction with dilatation above, unless it is prevented by extensive periduodenitis. Sometimes the duodenal wall appears to be flaccid.[4]

## Treatment

Surgery is the only treatment of this condition. The reported cases show a marked eclecticism. In some cases resection of the pancreatic ring was carried out, associated in some cases with a duodenal plastic procedure, in others with a gastroenteroanastomosis and in others with a duodenojejunostomy. In other cases division of the ring with duodenal plastic procedure was carried out. Thus, anastomatic interventions have been preferred by the majority of authors, but when the malformation is associated with duodenal ulcer gastroduodenal resection is preferable. Either resection or simple division of the pancreatic ring exposes the patient to the risk of a pancreatic fistula as often a pancreatic duct of considerable size is present in the ring, and reintervention which execution of an anatomosis may become necessary after a short while. [4]

Recently 33 surgically treated cases of annular pancreas have been reported and 40 cases have been found incidentally on autopsy and we add the following case.

## Case Report

A 45 year old white woman admitted to the hospital on December 4, 1957 with a chief complaint of pain in the right upper quadrant and epigastrium. She also complained of nausea and occasional vomiting, mostly after meals. On the day of admission she had pain in the right upper quadrant and in the epigastrium.

*Previous History:* She was Para III and gravida III and had experienced the usual childhood diseases in addition to a tonsillectomy. Three years before admission, she was operated upon because of low abdominal pain, and a ruptured "chocolate cyst" was found. Right oophorectomy and appendectomy were performed. Although very small gall stones were palpated in the gallbladder during surgery, none were demonstrated by x-ray.

*Physical Examination:* There was considerable epigastric and right upper quadrant tenderness on palpation. No mass was palpated. Her temperature was normal.

*Laboratory Evaluation:* A white blood cell count was 10,900 per cubic mm., hemoglobin 11.6 Gm. per 100 cc., hematocrit 34 per cent, with differential segmented forms 59, band cells 2 per cent, eosinophils 3 per cent, and lymphocytes 36 per cent. Urinalysis was normal with specific gravity 1.016. An intravenous pyelogram was performed and revealed duplication of the pelvis and ureter on the right. There was slight ptosis of the right kidney.

*Operation:* The preoperative diagnosis was cholelithiasis. On December 5, 1957, the peritoneal cavity was entered through a right upper rectus (muscle splitting) incision. No stones were felt in the gallbladder, and the gallbladder appeared normal in size. There were many lymph nodes in the lesser and greater curvatures of the stomach, which were larger than normal and inflammatory. A large node on the

hepatic pedicle measured about 2½ cm. in length. Part of this node was freed by sharp and blunt dissection and removed. A node was also removed for biopsy from the greater curvature. There was a nodular area on the superior wall of the first portion of the duodenum. This was light gray and about 1½ centimeters in diameter. A wedge resection was performed and the edges of the duodenal wall were closed with two layers of sutures transversely in the manner of Connell. The right kidney was enlarged and somewhat irregular. The uterus was palpated and found to be fibrous and finely nodular. There were a few adhesions in the pelvis. A routine closure was carried out.

*Pathological Examination—Microscopic:* Sections of the wall of the duodenum showed rounded lobules of pancreatic tissue lying in submucosa and between the bundles of muscle of the muscularis. These rounded masses were well differentiated pancreatic tissue composed of acini and small ducts with some inflammatory fibrosis of the superficial nodules. Their presence within the muscularis of the wall of the duodenum and in the submucosa indicate ectopic position. There was no evidence of malignancy. Sections of the various lymph nodes showed moderate reactive hyperplasia.

The patient was discharged eight days after the operation in good condition and with the wound healed.

The postoperative diagnosis was *ectopic pancreatic tissue around the first portion of the duodenum.*

## Second Admission

The patient was readmitted on August 15, 1959 because of burning epigastric pain and nausea half an hour after meals for the past three weeks. No other gastrointestinal symptoms were present. She had lost 7 pounds in the past three weeks. Her temperature was normal, and there were no abnormal findings in her routine laboratory evaluation except the hemoglobin was 10 Gm. per 100 cc. and the hematocrit was 33 per cent.

Radiologic examination of the upper gastrointestinal system revealed a normal esophagus and stomach. There was some radiolucency of the duodenal bulb at the time of fluoroscopy, but films revealed the bulb to change in appearance, the deformity apparently being due to extrinsic pressure or to adhesions from previous surgery.

*Operation:* On September 8, 1959, the peritoneal cavity was entered through a midline incision. There were adhesions between the peritoneum and duodenum, between the duodenum and the gallbladder, and between the duodenum and pyloric area of the stomach. Lysis of these adhesions was done. The pyloric area of the stomach and the duodenum were retracted and the pancreas located. There was found to be aberrant pancreatic tissue in the old duodenal scar about 1 to 1½ cm. in width and continuing with the head of the pancreas, as a lingula about ½ cm. in width. This tissue had all the macroscopic characteristics of pancreatic tissue and was about one inch below the pylorus.

First, this aberrant tissue close to the head of the pancreas was resected, and the bleeders (and also, in most probability, the duct) were clamped and ligated. Then the aberrant pancreatic tissue inferior and anterior to the old duodenal scar as well as the old duodenal scar itself were clamped between two Babcock clamps, and an elliptical incision was made removing all the aberrant pancreatic tissue and the old duodenal scar with the lingula and a portion of the wall of the duodenum.

The operation was completed closing the duodenum in layers with Connell suture of gastrointestinal catgut and reinforced by interrupted sutures of cotton. The patient left the operating room in good condition.

The pathological diagnosis from the specimen was *"cystic inflamed accessory pancreatic duct,* and old repair process of the duodenal wall."

The patient was dismissed from the hospital on the seventh postoperative day, apparently cured. A follow-up re-examination later showed the patient was free from symptoms and her general condition was good.

## Discussion

In the case presented, special emphasis has been placed on the following facts:

It is not necessary that the annular pancreas form a complete ring around the duodenum. In the case presented it was not complete and for this reason I chose to call the disorder aberrant annular pancreas. The most important thing is the connection between the annular pancreatic tissue and the head of the pancreas with a duct. In this case we found such an accessory pancreatic duct.

With regard to treatment, it probably would be advisable in a case similar to the one described to perform a complete resection of the aberrant pancreatic tissue with complete separation from the head of the pancreas, to remove more of the apparently normal duodenal wall between the aberrant or annular pancreatic tissue and the head of the pancreas, and to follow this with a duodenal plastic procedure. Proper ligation close to the head of the pancreas should be carried out because of the possible presence of a sizable pancreatic duct. Division or partial resection of the pancreatic ring entails the risk of the formation of a pancreatic fistula. Partial resection does not completely eliminate the duodenal stenosis.

In this case the symptoms returned after the first operation because of the inflammatory process set up in the remaining annular pancreatic tissue with the "cystic inflamed accessory pancreatic duct" found by the pathologist. A fistula might possibly have formed here at a later time due to an increase in the inflammatory process.

## Summary

The classification, the morphology and histology, the embryology and theories of the origin of annular pancreas, the physiology and pathology, the clinical picture and the x-ray findings of the annular pancreas have all been discussed.

A case of aberrant annular pancreas has been presented and discussed.

Acknowledgment: The author wishes to express thanks to Dr. John Thomas for his permission to use the case presented in this article.

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# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT P. CARSON, M.D., *President*

PRESENTATION OF CASE

A SIXTY-NINE YEAR OLD Negro woman was referred to Ohio State University Clinic one year before her admission to the Hospital, because of intermittent epigastric pain, nausea, and vomiting of nine months' duration. The pain was characterized as sharp and severe and did not radiate. Often the patient deliberately induced emesis to get relief from this pain. The emesis was described as yellow-green and bitter. These symptoms were not related to meals. The patient denied hematemesis, melena, jaundice, or acholic stools. Her weight had been stable. X-ray studies showed a sliding hiatal hernia without evidence of esophagitis. The gallbladder failed to visualize with oral cholecystograms on two occasions. An intravenous cholangiogram visualized only the common duct, which appeared normal. Cholecystectomy was advised, but the patient refused.

For the next year the patient was seen in the Outpatient Department and treated with diet and antacids. She continued to have intermittent episodes of epigastric distress and vomiting. She was admitted to the Medical Service because her symptoms progressed. Since her last visit to the clinic three months prior to admission she had had almost continual epigastric distress associated with nausea. She had lost 21 lbs. There had been no change in her stool or urine.

### Physical Examination

On physical examination the blood pressure was 120/60, pulse rate 60 per minute, respiratory rate 14 per minute, and temperature 99°F. She appeared extremely dehydrated, poorly nourished, and both acutely and chronically ill. The lungs were clear to auscultation and percussion. The abdomen was soft and slightly tender, particularly in the right upper quadrant. The liver margin was at the level of the umbilicus and was described as hard and tender; no nodules were noted. There was 1 plus bilateral pedal edema.

### Laboratory Data

The hematocrit was 35.5 per cent; the hemoglobin was 10.4 Gm./100 ml.; the white blood cell count was 12,500 per cu. mm. with 7 per cent nonsegmented and 75 per cent segmented neutrophils, 16 per cent lymphocytes and 2 per cent eosinophils. The urine was normal. The serum sodium was 135 mEq., the potassium 3.8 mEq., and chlorides 81 mEq. L. The total protein was 5.7 Gm./100 ml. with an albumin of 3.2 Gm. and a globulin of 2.5 Gm. The direct bilirubin was 0.3 mg./100 ml.; total cholesterol was 99 mg./100 ml. with 57 per cent esters. The prothrombin time was 65 per cent of normal. Guaiac tests of the stool shortly after admission were positive. Bromsulphalein test showed 26 per cent retention. A needle biopsy of the liver was reported as normal.

Submitted February 27, 1962.

*Presented by*

- Richard W. Zollinger, M.D., Columbus, and
- Emmerich von Haam, M.D., Columbus.

Edited by Dr. von Haam.

### Hospital Course

The patient continued to have intermittent vomiting while in the hospital. Her temperature ranged from 99 to 101°F. for the three-week period preceding surgery. It was difficult to maintain her electrolytes near normal values. X-ray showed a mass of fist size behind the gastric antrum pushing the duodenal bulb and the first portion of the duodenum anteriorly but not invading either of these structures. Because of this x-ray finding an exploratory laparotomy was advised and the patient was transferred to the Surgical Service. Five days preoperatively she developed a temperature of 100.6°F. with tachypnea. There were no positive physical findings in the chest, but an x-ray showed a consolidation in the right lower lobe.

An exploratory laparotomy was done three weeks following her admission. Postoperatively the patient became oliguric and subsequently hypotensive. She was digitalized and maintained on vasopressors. Gradually her urinary output increased, and she was started on alimentation. She was apparently making a

gradual but satisfactory recovery when on the tenth postoperative day, while talking to the nurse, the patient suddenly gasped and died.

## CLINICAL DISCUSSION

DR. R. W. ZOLLINGER: As we read through this history the first thing that strikes us is the complaint of nausea and vomiting of nine months' duration associated with epigastric pain. Immediately my thoughts are centered around the areas of the stomach, duodenum, pancreas, liver, gallbladder and perhaps the transverse colon. Since this pain was intermittent, we might associate it with gastric ulcer, duodenal ulcer, perhaps with pancreatitis and cholelithiasis, because we all know that in these conditions this intermittency is probable and possible. The fact that the pain did not radiate would tend if anything to lead us away from the thought of cholecystitis with cholelithiasis. Although not pathognomonic, usually cholecystitis and cholelithiasis cause pain in the right upper quadrant radiating to the scapular area. So this would be the only clue that I would get here which would lead me away from gallbladder disease.

### Probably Not Peptic Ulcer

Now the patient did not have any food-pain relief relationship, but they do mention the fact that this patient did get relief from vomiting. The fact that there is no food-pain relief relationship leads me away again from the idea that this is a gastric or duodenal ulcer. That does not mean that this patient could not have had a perforated ulcer since we know that this food-pain relief relationship stops the minute perforation takes place. Now the fact that the patient got relief by vomiting may mean little or mean much. I think everybody who has abdominal distress, whether it is appendicitis or something else, tends to get relief from this distress by vomiting. On the other hand, such a story could suggest that this patient had edema of the pyloric end of the stomach or of the duodenum from an ulcer in this area, that her stomach became distended with accumulation of secretion and food due to some pyloric blockage, and she would attempt to vomit to relieve this. However, there is one thing wrong with this assumption and that is the fact that the emesis was green. This speaks against the idea of pyloric blockage, because bile regurgitated back through the pylorus.

This leads me away from the idea of pyloric obstruction secondary to duodenal or gastric ulceration. The fact that the vomitus was yellow also suggests that this patient had a patent common duct. Percentage-wise, the probabilities lead me away from the possibility that this patient had a cancer of the head of the pancreas. I do not deny that because she vomited bile this patient could not have an intermittent blockage from a stone in the common duct or from a malignancy in the ampulla Vater. This is quite possible.

It is of no help that the patient did not vomit blood. Had she vomited blood, we would have thought of a lesion within the gastrointestinal tract and in all probability a lesion proximal to the ligament of Treitz. The fact that the patient had a negative melena does not help either, because here again a positive finding would localize this lesion to somewhere in the intestinal tract. Since the patient had no jaundice or acholic stools, we can deduce from her original story about vomiting of bile that blockage of the common duct from a carcinoma of the head of the pancreas is very unlikely. So up to now we have considered the possibility of gastric ulcer, duodenal ulcer, and because of possible blockage at the antral end of the stomach a malignancy of the stomach. The food-pain relationship has tended to rule out ulcers and the fact that the pylorus is patent tends to rule out a gastric malignancy. Her cholecystograms and her intravenous cholangiogram failed to visualize the gallbladder, which speaks for the presence of gallbladder disease. However, she refused cholecystectomy.

The patient was placed on diet and antacids, but her symptoms continued and her intermittent pain became persistent after 14 months. We notice that on admission the patient was quite dehydrated and emaciated, and that the main physical finding was an enlarged liver. There was also tenderness in the right upper quadrant and she had a 1 plus bilateral pedal edema. Obviously this patient had been unable to eat, had had apparently persistent vomiting because the laboratory data showed a hypochloremic alkalosis with some hypokaliemia and some reduction in blood proteins. I wondered if we should consider her pedal edema as possible evidence of a thrombophlebitis, but a 1 plus does not mean too much for a patient sick in bed. Although her blood proteins were falling, they were not low enough to explain the edema on the basis of protein deficiency.

### Abnormal Hepatic Function

The other positive findings in the laboratory data point toward a damaged liver, and these are the low cholesterol, the BSP retention and the elevated direct bilirubin. But then they obtained a needle biopsy with a normal finding, which throws out the possibility that the liver enlargement was due to cirrhosis or some other diffuse process. I can only suppose that this depletion of liver function is due to some process which is involving the liver but is leaving some normal areas, and the only way I can explain this liver enlargement is by metastatic disease. This mass in the right upper quadrant made me think for a minute of hypernephroma, but there is no description to show that the mass was occupying the flank, as I would expect a hypernephroma to do. Her urine was negative, although I admit that perhaps half the cases of renal cell carcinoma may not show blood in the urine.

During her stay in the hospital they tried first

to hydrate the patient and replace her loss of blood, water and electrolytes and then to explore her retroperitoneal mass. Obviously the usual retroperitoneal tumors that we think about are the lymphomas and tumors of the pancreas, either a cyst or a carcinoma. The fact that this patient had had pain in the epigastrium which was intermittent to begin with, does not rule out carcinoma of the body or tail of the pancreas. The fact that the patient had no jaundice would tend to support the suggestion that she could have carcinoma of the pancreas. Pain in pancreatitis is not always a continuous pain, nor is painless jaundice diagnostic of carcinoma of the pancreas as stated in most texts. This is a fallacy, because the majority of patients with carcinoma of the pancreas, whether of the head, body or tail, still suffer pain, and it is wrong to say that painless jaundice and a large gallbladder are diagnostic of cancer of the head of the pancreas.

### Intermittent Pain in Pancreatic Disease

Intermittency of pain can occur with a lesion in the pancreas whenever the ducts are blocked, and pain occurs after stimulation of pancreatic secretion by meals. The fact that the pain became persistent could mean that the lesion here had extended and involved more of the retroperitoneal tissues with its nerves and ganglia. I do not know how we could diagnose a lymphoma since we have no clues of any blood dyscrasia in her peripheral blood. The only thing that the blood count does suggest is some leukocytosis, which does not mean much in the face of her dehydration. Her slight shift to the left suggests that she did have some inflammatory process somewhere, or it might be due to some necrosis of the tumor. They probably decided on surgery as a diagnostic procedure to find out what this mass was.

Five days before surgery the patient developed a pain in the lower lobe of the right lung. Although the physical examination of her chest remained negative, her x-ray picture showed a consolidation in her right lower lobe which probably represents a pulmonary embolism with associated infarction. We know that patients with carcinoma of the pancreas have a tendency to develop spontaneous thrombosis of many veins and such a thrombosis of her femoral veins could account for her bilateral pedal edema and produce an embolism with an infarct in her right lower lobe. After surgery the patient had a difficult recovery but finally started to improve. Then suddenly on the tenth postoperative day she had a massive pulmonary embolism and died.

The only way I can fit all these symptoms and findings together is to suggest that the original pain and discomfort along with the development of her retroperitoneal mass indicate a carcinoma of the pancreas without involvement of the head and bile ducts but with extension and metastasis to the liver. In the course of her ailment the patient developed venous thrombosis of her iliofemoral segments, had a right lower lobe pulmonary infarction and died from a massive pulmonary embolism.

#### CLINICAL DIAGNOSIS

1. Carcinoma of the pancreas.
2. Metastasis to the liver.
3. Pulmonary infarcts.
4. Massive pulmonary embolism.

#### PATHOLOGICAL DIAGNOSIS

1. Adenocarcinoma of the gallbladder.
2. Recent pulmonary infarction.
3. Bilateral thrombosis of the pulmonary artery.
4. Chronic pancreatitis.

#### PATHOLOGICAL DISCUSSION

DR. VON HAAM: At autopsy the heart weighed 300 Gm. and showed only a minimal degree of coronary artery disease. The main trunk of the right pulmonary artery was filled with a recent thrombus which was adherent to the vessel wall and extended into the smaller branches. The possibility that this thrombus started around a small embolus cannot be denied, but we felt that most of the occlusion of the lumen was due to an actual thrombus. Some of the branches of the left pulmonary artery also were occluded by antemortem blood clots. Both lungs contained firm, dark red areas varying in size from 5 to 7 cm. in diameter, located in both lower lobes. They represented recent infarcts.

The abdominal cavity showed a recent jejunostomy and a recent gastrostomy. There was also a well functioning gastrojejunostomy. The peritoneal surface of the intestines was slightly dull and covered with a few streaks of fibrinous exudate. A large, fungating mass could be found in the gallbladder region, and neither the gallbladder nor the cystic duct could be identified in the mass. A small cavity found in this mass contained two gallstones. The mass was adherent to the anterior margin of the liver and infiltrated the hepatoduodenal ligament. The common duct could be traced into this area. It was patent and appeared free of tumor. The mass also infiltrated the first portion of the duodenum without perforating into its lumen. The duodenal mucosa showed two recent ulcers at some distance from the infiltrating tumor mass.

The liver weighed 2000 Gm. and showed a uniform red-brown color. The inferior surface of the right liver lobe was firmly attached to the mass but seemed separated from it by a thick area of fibrosis. A small abscess which contained some thick greenish pus was present in the angle between the mass and the lower liver margin. The liver was free of metastatic tumor nodules.

The pancreas was dissected easily, was of firm consistency and showed a normal acinolobular pattern. The pancreatic duct drained separately from the common duct into the duodenum. The remain-

ing portion of the intestine and the structures of the retroperitoneal space appeared grossly normal.

### Microscopic Examination

Microscopic sections through the lung showed rather recent pulmonary infarctions without evidence of pneumonia. Sections through the liver showed evidence of old pericholangeal fibrosis and severe thickening of Glisson's capsule. Sections through the tumor mass revealed a rather well differentiated adenocarcinoma probably arising from the gallbladder wall. The tumor infiltrated the mesenteric fat tissue, invaded the lymph vessels and invaded the serous and muscular layers of the duodenum. Sections of the pancreas showed distinct periductal fibrosis without evidence of recent inflammatory changes. There was no evidence of fat necrosis, and the tumor did not invade the pancreas. Both kidneys showed moderately advanced chronic pyelonephritis.

*In summary* then, we have before us a case of adenocarcinoma of the gallbladder with abscess formation and invasion of the wall of the duodenum. There was also evidence of bile duct disease in the liver and chronic pancreatitis.

Carcinoma of the gallbladder is an unusual tumor in our experience. It is difficult to diagnose in its early stage and usually is associated with previous gallbladder disease. For this reason it is much more common in women than men. In a recent evaluation of 642 cases collected from the literature, only 2.1 per cent showed a five-year survival. In most cases it appears in the form of adenocarcinoma but occasionally a squamous cell carcinoma may be found. In contrast to carcinoma of the head of the pancreas or carcinoma involving the common duct, jaundice is usually a late symptom, and this fact should be considered in the differential diagnosis. The tumor often invades the liver at the site of the gallbladder bed, thus obscuring the lower liver margin. Carcinoma of the gallbladder also predisposes to spontaneous thrombosis in a similar way as does carcinoma of the pancreas.

### Reference

1. James, A. G.: Cancer Prognosis Manual, p. 43. American Cancer Society, Inc., New York, N. Y.

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ENVIRONMENTAL FACTORS IN CORONARY ARTERY DISEASE. — It appears that the best prophylactic measures against clinical coronary artery disease are subsistence on a diet low in animal fat and reduction in the tempo of modern life. The fact that stress and high fat diet often coexist is clearly borne out by a variety of well documented epidemiologic surveys. The dependence of each upon the other for pathologic significance makes it difficult to ascertain their respective roles in the pathogenesis of coronary atherosclerosis; a high fat diet and a stressful mode of life must be considered a highly lethal combination.

Drastic dietary fat restriction will probably never become popular in areas where it is not already prevalent. Therefore, only one alternative exists, i. e., moderate reduction of dietary fat compatible with tolerance and the adoption of a more prudent way of life. The fact that many individuals subsist on a typical American diet all their lives without developing clinical coronary disease provides hope that hormonal, biochemical, or other means may yet be found to extend this "immunity" to all mankind. It seems improbable that management directed solely at reduction of blood cholesterol, without simultaneous efforts to neutralize psychophysiologic mechanisms induced by environmental stress, can be significantly effective. — *Abstract:* Henry I. Russek, M. D., Staten Island, New York: *Angiology*, 12:239-243, June, 1961.

# Management of Shock in Acute Myocardial Infarction

A. CARLTON ERNSTENE, M.D.*

SHOCK is one of the most serious complications of acute myocardial infarction. Its characteristic manifestations are cyanotic pallor, cold, clammy skin, dyspnea and air hunger, thirst, weakness, restlessness, faintness or stupor, oliguria or anuria, rapid thready pulse, and hypotension.

Although knowledge of the mechanism of the syndrome is still incomplete, the primary fault is a profound reduction in cardiac output. A low cardiac output alone, however, does not result in shock. Other factors, including failure of peripheral vascular tone and impairment of venous return to the heart, must be present. Nevertheless, the key to successful treatment lies in the employment of measures to support the heart and augment cardiac output.

## Use of Vasopressor Amines

The most valuable single measure in the treatment of shock is the administration of vasopressor drugs. The beneficial effect of these agents is due in part to their peripheral vasoconstrictive action but mainly to their direct action on the myocardium. The latter effect brings about an increase in myocardial contractility and cardiac output with improvement of aortic blood pressure and coronary blood flow. There is general agreement today that one of the vasopressor amines should be administered in all cases of shock. In addition, their use is indicated in the absence of shock whenever the systolic arterial pressure falls to approximately 80 mm. Hg. in a previously normotensive patient or to a relatively hypotensive level in a person with earlier hypertension. The preparations most commonly employed are levarterenol (Levophed®) and metaraminol (Aramine®). Levarterenol is the more commonly used.

It must be given by intravenous injection and has the disadvantage that inadvertent infiltration of the subcutaneous tissues may result in local ischemic necrosis. Treatment is started with 4 or 8 mg. (1 or 2 ampules) diluted in 1000 cc. of 5 per cent glucose in distilled water administered by continuous slow intravenous drip in amounts sufficient to maintain a systolic pressure of 100-120 mm. Hg. When this goal is not achieved by less than 40 drops per minute, it is advisable to increase the strength of the solution rather than the rate of flow.

Mild shock usually responds promptly, and occasionally even severe cases are corrected. In the few studies, however, in which the effect of vasopressor agents has been considered separately in mild and severe shock, the mortality rate in severe shock does not appear to have improved significantly.

## Other Measures in Treatment

Pain and restlessness should be controlled by morphine or meperidine hydrochloride (Demerol®). Oxygen should be administered in all cases, usually by intranasal catheter at a rate of 6 to 8 liters per minute.

In shock due to acute myocardial infarction, there is no significant reduction in circulating blood volume. This explains the lack of beneficial effect of intravenous or intra-arterial blood transfusions.

There has been much past uncertainty as to the value of digitalis in the treatment of shock due to myocardial infarction, but as it has become apparent that the primary fault in this form of shock is acute heart failure, employment of the drug has become a rational procedure. Whenever shock is accompanied by acute pulmonary edema, congestive heart failure, atrial fibrillation or flutter, or ectopic supraventricular tachycardia, there can be no question as to its need, and in these situations lanatoside C (Cedilanid®) by intravenous injection usually is the preparation of choice. Even in the absence of these disturbances, however, routine rapid digitalization appears advisable, by the oral route when possible and otherwise by intravenous administration. A mercurial diuretic should be given when congestive heart failure is present. Acute pulmonary edema calls for the additional use of aminophylline by the intravenous route. Shock in acute myocardial infarction is accompanied occasionally by a very slow heart rate due to sinus bradycardia, second-degree atrio-ventricular block or complete atrio-ventricular dissociation. In sinus bradycardia, atropine sulphate, 1 mg., intravenously may bring about a rise in rate and an increase in systolic pressure.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

*Dr. Ernstene, Cleveland, is Chairman, Division of Medicine, Cleveland Clinic.

# Maternal Deaths Involving Cardiac Arrest

## With Comment of Consulting Thoracic and Cardiac Surgeon

By the OSMA COMMITTEE ON MATERNAL HEALTH

THROUGHOUT the literature it has been pointed out that cardiac arrest, as a cause of death, is merely a concomitant physiological or pathological phenomenon frequently employed as an impressive term to actually replace or supplement the basic etiology underlying the primary cause of death in either an obscure or obvious fatality. Various cases filed in the Ohio Maternal Mortality Study corroborate these observations. Herewith the Committee presents three cases "signed out" with cardiac arrest as the cause of death.

### Case No. 247

This patient was a 22 year old, white, primipara, who died 84 hours postpartum. Her past history was not reported; no specific allergies were known. Little is known about her prenatal course, except that she gained 30 pounds during the pregnancy. On January 3 she was admitted to the hospital (presumably at term) in labor. Details concerning the course of labor were not reported; analgesia was obtained by administering scopolamine and Nisentil®. At 1:21 p. m. she was delivered of a living baby (weight not stated), using Elliott forceps, over an episiotomy. The delivery was accomplished under nitrous oxide-oxygen anesthesia administered by a physician.

Seventeen minutes later the placenta was delivered, with an estimated blood loss of 200 cc. One ampule of Pitocin® was administered intramuscularly; immediately, respiratory and cardiac arrest followed! Oxygen was administered, Benedryl® was given intramuscularly. Although the blood pressure was 70/40 the pulse was regular and strong. Ten minutes later the patient received ephedrine 50 mg. (intramuscularly) 10 per cent Travert®, intravenously, containing Solu-cortef® 50 mg., and 4 cc. Levophed®. Meanwhile, medical consultation was obtained. The blood pressure raised to 120/60, then dropped to 70/50. Electrocardiographic monitoring was started; the cardiac action was erratic. At 2:06 p. m., following complete cardiac arrest, the chest was opened and cardiac massage was begun. This was followed by cardiac response at 2:09 p. m. when respirations were 18 per minute, blood pressure 100/70, the pulse rate 100 per minute, but the pupils were not responsive to light. At 7:00 p. m., during convulsions, the patient bit her tongue; the pupils reacted to light.

The following day the patient had convulsions lasting two or three minutes; she responded to the spoken word but could not speak. Urinary output was reported satisfactory. On January 5 the patient was in semicomatose condition, pupils reacted to light, and there were no more convulsions. About 7:00 p. m. the patient developed respiratory embarrassment; a tracheotomy was performed. The temperature was 102° The following day convulsions occurred frequently, the blood pressure was 148/80, temperature 102°. Oxygen was administered. On January 7 tachycardia developed and by 12:10 a. m., the blood pressure disappeared: death followed. Autopsy permission was not obtained.

*Cause of Death* (Certificate): Cerebral anoxia, due to cardiac arrest, probably due to anaphylactic shock due to administration of Pitocin; pregnancy, term, delivered.

### Comment

With keen interest the Committee studied available facts in the case, voicing regret that more details were lacking, and that autopsy examination had not been permitted. Members were puzzled in establishing a cause for the cardiac arrest. Amniotic fluid embolism and an error in the nitrous oxide-oxygen anesthesia technique were discussed as possibilities. No Committee member could recall a similar fatal incident occurring following the administration of Pitocin to a patient. After a prolonged discussion, the Committee voted this a nonpreventable maternal death, unavoidable catastrophe.

### Case No. 324

This patient was a 28 year old, colored, Para I, cesarean I, who died one day postpartum (postoperative). Her past history revealed nothing of import. In a previous term pregnancy she was delivered three years before by moderate Scanzoni maneuver, mid-forceps, of a living baby 2960 grams weight. The patient registered for her second pregnancy in the fourth month, with last menstrual period January 8, and made nine prenatal visits; the prenatal course was uneventful. The diagonal conjugate was 10.2 cm. At term, on October 18, the patient was admitted at 7:00 p. m. in labor, with ruptured membranes. After 11 hours of labor, *progress* ceased; the fetal head was at plus 1 station (condition of cervix not reported), left occipito-anterior position. Previous pelvimetry indicated a borderline pelvis. Five milligrams of Pontocaine® was injected intrathecally by a physician, and forceps were applied in an effort to advance the fetal head; the attempt failed and a cesarean section was decided upon. Further preparation for the operation included a second intrathecal injection of Pontocaine 8 mg., administered 40 minutes after the initial one.

Seven minutes after the second spinal injection, during preparation of the abdomen, cardiac arrest occurred. Thoracotomy was performed and within eight minutes the heart was "beating on its own." Simultaneously, with the thoracic operation a classical cesarean operation was performed, delivering a living baby 3590 grams in weight. The treatment given omitted details, except for digitalization. Three hours later, when there was massive atelectasis of the right

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

lung bronchoscopy and tracheotomy were performed, the former removing a "mucous plug" from the "right main stem bronchus." In the next 24 hours the patient developed intermittent generalized convulsive seizures. Twenty-seven hours after the cardiac arrest the patient died, on October 20. There was no autopsy.

*Cause of Death* (Certificate): Cerebral anoxia; cardiac arrest; classical cesarean section; term pregnancy delivered.

### Comment

The Committee reviewed data in the case, noting that facts and features were presented in good detail and chronological sequence. Members felt that the total dose of anesthetic agent administered intraspinally was excessive and probably resulted in arterial hypotension, although pulse and blood pressure readings were not recorded. It was believed that cerebral and myocardial anoxia accompanied this hypotension, resulting in cardiac arrest. The records revealed no evidence that a (prophylactic) intravenous infusion was started prior to the spinal injection. After prolonged discussion, the Committee voted this a preventable maternal death.

## Case No. 327

This patient was a 23 year old, white, "primipara," who died an hour and 20 minutes postpartum (post-cesarean section). The past history was not remarkable. She registered with her physician in the second month of pregnancy, making 11 subsequent visits; weight gain exceeded 30 pounds; albuminuria, hypertension and edema developed in the 28th week of gestation, in spite of dietary control and bulk producing medications, ammonium chloride, diuretics and Rauwolfia. On October 27 (at term) the patient was admitted in labor, with ruptured membranes. She had modest hypertension (135/90), 2 plus pitting edema, and 2 plus albuminuria. The cervix was 1 cm. dilated, the fetal head was not engaged in the pelvis. Medication consisted of Seconal® gr. 1½, Dermerol® 100 mg., and scopolamine gr. 1/150.

Labor progressed slowly. At 9:00 a. m. additional medication included Compazine® 10 mg. and Seconal gr. 1½. The blood pressure fluctuated between 130/90 and 160/110. Consultation was obtained, membranes were ruptured artificially, cervix 4-5 cm. ("dilatation by consultant"?), station minus 1 at 10:20 a. m. October 28; a Pitocin "drip" was started to stimulate the desultory labor. X-ray pelvimetry reported a pelvis within normal limits, fetal head presenting in left occipitoposterior position. By 3:30 p. m. the cervix was 7 cm. dilated, presenting part at station "0" to plus 1, contractions poor in frequency and quality. The clinical diagnosis was "excessively large infant"; cesarean section was elected to deliver the patient, indication "cephalopelvic disproportion."

At 4:15 p. m. a spinal anesthetic was administered, using Pontocaine 6 mg. and procaine 30 mg., at *first* lumbar interspace and *second* lumbar interspace, respectively, (two injections); this was administered by a physician (not an anesthesiologist). A low cervical cesarian section was done quickly, delivering a living 8 lb. 12½ oz. baby at 4:27 p. m. Dark blood was noted but meanwhile, at 4:25 p. m., the patient developed sudden dyspnea; positive pressure oxygen was administered (blood pressure and pulse rate readings not recorded). The record indicates the blood pressure fell, the abdominal aorta revealed no pulsations and the respirations had ceased. Quickly, the chest was opened and cardiac massage was instituted; the heart rate soon went to 40 beats per minute, then developed fibrillation which was controlled eventually with the defibrillator and intracardiac administration of Adrenalin® and procaine. Levophed was administered through a cutdown into the saphenous vein. The patient pursued a downhill course and died in spite of therapy, at 5:45 p. m. Autopsy permission was obtained.

*Pathological Diagnosis:* Acute respiratory insufficiency with cardiac arrest; term pregnancy with uterine inertia and preeclampsia; acute toxic necrotic degenerative eclamptic changes in the liver; multiple highly placed lumbar punctures, etc.

### Comment

The Committee noted with appreciation the detailed clinical summary of this case submitted with a complete autopsy protocol. The course of events described a primigravidous preeclamptic patient at term in labor with cephalopelvic disproportion. Members of the Committee commented upon a lack of immediate treatment of preeclampsia, after admission. The decision to perform a cesarean operation after a "trial of labor" was considered logical, especially following the unsuccessful use of a "Pit-drip." However, members wondered why two separate injections (total large dose) of anesthetic agent were placed in the subdural space for an anesthesia, at a *high level!* No mention was made of a (prophylactic) intravenous infusion administered before the intraspinal medications were given! Although specific blood pressures were not recorded, members believed an arterial *hypotension* developed, resulting in cerebral anoxia and cardiac arrest as the anesthetic agent ascended through the subdural space. Members further agreed that the case represented an "anesthetic death," although the cause of death was listed as "cardiac arrest." The Committee voted this case a preventable maternal death.

### Comment of Consultant

The following comment of a consultant, who is a specialist in thoracic and cardiac surgery was furnished at the request of the Committee:

"The majority of cases of cardiac arrest are due to severe hemorrhage or to a period of inadequate ventilation. Both eventuate in myocardial hypoxia, but with the latter there is the added factor of hypercarbia. The term ventilation implies not only getting oxygen into the lung (which is easiest because of the high concentrations of this gas readily available to the anesthetist), but getting carbon dioxide out of the lung. Unnoticed sudden changes in blood pH can be produced with inadequate respiratory exchange. Factors like obesity, breath holding or struggling, tracheal secretions, drug depression and associated disease states may greatly compromise the ventilatory effort. Vagal stimulation and the other oft mentioned esoteric causes of cardiac irritability may play a role, but they become operative only after there has been a preconditioning by hypoxia and/or hypercarbia.

"Case No. 247. At the time the blood pressure was reported, the patient was in shock. It is difficult to estimate its duration. However, the low blood pressure could have been due to factors discussed above. The response to vasomotor drugs (a transitory restoration of blood pressure, followed again by shock) is rather typical of hypotension due to hypoxia.

"Hypothermia (32°C) induced immediately after

cardiac resuscitation might have been of value in managing the cerebral complication.

"Although it is difficult to take a position when the facts are so limited, I would be inclined to consider this patient's death a preventable death.

"Case No. 324. I would agree with the committee that this was a preventable death. It is probable that the excessive spinal anesthetic also caused respiratory depression in addition to its usual effects on the vascular bed.

"All unconscious patients should have a tracheotomy in order to assure a clear airway. Again, induced hypothermia might have been helpful in controlling cerebral edema.

"Case No. 327. I would agree with the committee that this should be considered a preventable death. The same factors responsible for death of the patient (Case 324) should be applied here. There is considerable question in my mind whether either of these patients had an adequate respiratory exchange following the injection of the spinal anesthetic. This patient also had the complicating factor of preeclampsia."

## Effective Weight Reduction Through Low-Calorie Diet

Weight loss always can be accomplished simply by reducing the calorie intake. Motivation is the principal requisite for successful weight reduction. Most overweight individuals, however, find it difficult to adhere to a restricted diet without adjuvant measures to curb the appetite. For such people, the most innocuous preparation which can produce a feeling of satiety should be used.

The critical period in a weight-reduction program often occurs at the end of four to six weeks. It is during this phase that medical supervision is important.

The records of 120 obese patients engaged in weight-reduction programs were analyzed. The usefulness of a vitamin-mineral candy to control hunger was evaluated in 80 of these patients. A comparison was made with 20 exceptional, ideal control patients treated solely by means of a strict low-calorie diet and with 20 other control patients treated by a similar diet plus a potent anorexigenic drug.

The results achieved by all three groups were virtually identical, demonstrating that any measure which enhances cooperation by motivated patients and promotes reduction of the calorie intake will lead to effective weight reduction.

The weight loss was satisfactory when a prudent diet was followed rather than a strict one, although the total amount lost was smaller. — Seymour Lionel Halpren, M. D., New York City: Effective Weight Reduction, *New York State Journal of Medicine,* 61:4205-4212, Dec. 15, 1961.

## Franklin County Pelvic Cancer Delay Committee Report

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee at its March 21, 1962 meeting.

Case No. 99: A 44 year old white woman, gravida IV, Para IV, was seen in her physician's office on January 4, ———, for a routine annual pelvic examination and a Papanicolaou vaginal smear. She had no complaints other than a lengthening of her menstrual periods from five to seven-eight days. Pelvic examination was essentially negative except for a 5 cc. right ovarian mass which was firm to palpation. A vaginal smear was taken (subsequently reported as Class I) and patient was instructed to return in three months for another pelvic examination. Because of family problems, she was unable to keep her appointment but did return again on June 8, at which time it was thought that the adnexal mass had remained the same or had slightly decreased in size. A Papanicolaou smear was taken and she was treated with thyroid gr. 1, daily for menometrorrhagia and asked to return in three months.

The patient was not seen again until January 12 of the next year, at which time she complained of menometrorrhagia and pelvic fullness. Examination revealed a 10 cc. firm right adnexal mass fixed to the uterus and a 5 cc. left adnexal mass replacing the left ovary. She was hospitalized and at laparotomy it was noted that both ovaries were replaced with solid ovarian tumors exhibiting surface growth but no evidence of ascites or peritoneal implants. A total hysterectomy, bilateral salpingo-oophorectomy was performed and she was subsequently discharged on her seventh postoperative day.

On the following July 10 she was referred to the Gynecology Tumor Clinic at Ohio State University Hospital because of ascites and a nodular cul-de-sac mass. Paracentesis performed at this time revealed blood-tinged straw colored fluid which was positive for malignant cells of ovarian origin. Therapy consisted of external irradiation and intraperitoneal nitrogen mustard.

### Comments

Ovarian carcinoma should be suspected in any patient with a unilateral or bilateral solid ovarian tumor regardless of size. Procrastination follow-up office examinations are indicated in an ovarian cyst 5 to 7 centimeters in size and for a limited period of time. Papanicolaou smears are of little value in the follow-up of ovarian carcinoma since exfoliated cells rarely make their way into the vaginal pool. The treatment of ovarian carcinoma with surface growth is generally total hysterectomy, bilateral salpingo-oophorectomy, omentectomy and external irradiation. To omit any of these therapeutic procedures constitutes less than ideal therapy for ovarian carcinoma.

*Physician Delay:* 18 months.

*Patient Delay:* 6 months.

## Menstruation and Crime

An investigation carried out in a women's prison revealed that almost half the women committed their crime during menstruation or the premenstruum. Premenstrual tension appears to be an important factor, and 63 per cent of the sufferers committed their crime at the time of their symptoms. — *British Medical Journal:* 5269:1752-1753, December 30, 1961.




# NEWS AND Organization Section

## Proceedings of The Council

### National Legislative Situation Reviewed; Reports of Many Committees Approved; Other Important Business Transacted

A REGULAR MEETING of The Council of the Ohio State Medical Association was held on Saturday and Sunday, March 17 and 18, 1962, at the headquarters office, Columbus. The following were in attendance in addition to members of The Council: Drs. John H. Budd, Cleveland, Richard L. Meiling, Columbus, Paul F. Orr, Perrysburg, Charles A. Sebastian, Cincinnati, Charles L. Hudson, Cleveland, Edmond K. Yantes, Wilmington, delegates to the AMA; Drs. P. John Robechek, Cleveland, Frederick P. Osgood, Toledo, J. Robert Hudson, Cincinnati, H. T. Pease, Wadsworth, alternate-delegates to the AMA; Mr. Charles H. Coghlan, Mr. Frank W. Van Holte, Dr. R. Dean Dooley, Columbus, representing Ohio Medical Indemnity, Inc.; Dr. Thomas E. Rardin, Columbus, Chairman, Committee on Education; Dr. Perry R. Ayres, Columbus, Editor, *The Ohio State Medical Journal*; Rev. Dr. Paul B. McCleave, Chicago, Director, Department of Medicine and Religion, American Medical Association; Mr. Wayne E. Stichter, Toledo, legal counsel; Messrs. Nelson, Saville, Page, Edgar, Moore and Traphagan from the headquarters staff.

#### Minutes Approved

Minutes of the meeting of The Council held on December 16-17, 1961 were approved by official action.

#### Membership Report

A report on membership was given by the Executive Secretary as follows: Ohio State Medical Association membership as of March 15, 1962, 8,583, of which 7,724 were affiliated with the AMA. These figures compared to 9,530 and 8,614, respectively, as of December 31, 1961.

#### Report by Executive Secretary

In his report Mr. Nelson also commented on the following: A suit filed by a group of Columbus attorneys seeking to enjoin the Bureau of Workmen's Compensation and the Industrial Commission from permitting laymen to engage in activities alleged to be the practice of law; a letter from the Ohio Department of Highways referring to a study being made to determine the cost of motor vehicle accidents, including medical and hospital costs of motor vehicle accident victims; new provisions in most of the insurance policies covering alleged malpractice which would protect the insured physician for acts or omissions while serving as a member of a formal accreditation or similar professional board or committee of a hospital or professional society; a survey on hospital utilization being made by the American Medical Association; a preliminary report of the special insurance committee on the results of a survey of the membership to determine interest in various group insurance plans. Mr. Nelson recommended to members of The Council that they make a point to discuss these matters when visiting their county medical societies and that they especially emphasize

the importance of active local hospital utilization committees.

### American Medical Education Foundation

In reporting as Director of Public Relations, Mr. Saville stated that the total amount collected by the American Medical Education Foundation in Ohio during 1961 was a record-breaking $63,177.41 from 2,073 contributors. Of this amount, the Woman's Auxiliary to the OSMA raised $28,081.51. In 1960, the amounts were $53,910.84 and $24,293, respectively, from 1,317 donors. He stated that the amount contributed in 1961 by physicians directly to Alumni Funds of medical schools was not yet available. That amount in 1960 was $199,091 from 4,172 Ohio physicians.

He also reported that gifts to Ohio's three medical schools from the total AMEF distribution in 1961, of $1,303,161.10 were: The Ohio State University, $15,293,03; University of Cincinnati, $13,792.10; Western Reserve University, $13,720.32.

### Public Service Newspaper Advertisements

Mr. Saville also discussed the series of public service newspaper advertisements prepared by the AMA in mat form for use by county medical societies. These ads are constructive in character, pointing out the positive programs of the medical profession and the various activities of county medical societies. He urged Councilors to encourage their county societies to finance the production of these ads in their local newspapers.

### Reports by Councilors

The next item of business was the reports of the Councilors on activities in their districts.

### Constitutions and Bylaws

The Council then acted favorably on amendments to the constitutions and bylaws adopted by several county medical societies, as follows:

**Hardin County**—An amendment adopted by the Hardin County Medical Society on November 14, 1961, increasing the dues of that society.

**Lorain County**—An amendment adopted by the Lorain County Medical Society in January, 1962, amending Chapter 5, Section 1, of its bylaws relating to dues.

**Lucas County** — Amendments adopted by the Academy of Medicine of Toledo and Lucas County on January 11, 1962.

**Medina County**—Amendments adopted by the Medina County Medical Society on January 18, amending Chapter 5, Section 1, of the bylaws of that society.

**Seneca County**—A new constitution and bylaws, patterned after the model constitution and bylaws, adopted by the Seneca County Medical Society on December 1, 1961.

**Hamilton County**—Amended articles of incorporation and code of regulations proposed by the Academy of Medicine of Cincinnati, subject to resubmission after officially adopted by the Academy. The Executive Secretary was instructed to notify the Cincinnati Academy of Medicine of this action and to transmit to the Academy a communication from Mr. Wayne E. Stichter, legal counsel of the OSMA, offering a number of suggested changes in wording for the purpose of improvement and clarification.

### New AMA Department of Medicine And Religion

The Rev. Dr. Paul B. McCleave, Director, Department of Medicine and Religion of the American Medical Association, was then introduced. Dr. McCleave discussed the purposes of this new department of the AMA and outlined some of the anticipated activities of his department. He stated that Ohio had been selected as one of eight pilot states and he asked The Council to voice the official cooperation of the Ohio State Medical Association. By official action, The Council voted to comply with the request that Ohio be a pilot state and offered the cooperation of the Association to Dr. McCleave and his department.

### Federal Legislation

Reports on the current situation in Washington with respect to H. R. 4222 were presented by Dr. Petznick, Dr. Robechek, Mr. Saville and Mr. Nelson. Drs. Petznick and Robechek reported on an official conference they and Dr. John D. Osmond, Jr., president of the Cleveland Academy of Medicine, had in Washington recently with Senator Lausche. Mr. Saville and Mr. Nelson reported on conversations they have had with several members of the U. S. House of Representatives. Also, they discussed some of the political maneuvering taking place and the forecasts of Washington observers with respect to the fate of H. R. 4222. Mr. Nelson presented figures on literature which has been supplied to Ohio physicians and others. He pointed out that since January 19 approximately 80,000 pieces of material had been distributed through the OSMA office or directly from the AMA to Ohio sources. Reference was made also to the legislative meeting held in Columbus, March 1, by the U. S. Chamber of Commerce at which compulsory health insurance was discussed, pointing out that the OSMA had cooperated with the Chamber of Commerce in promoting this meeting. Mr. Nelson pointed out that a step-up is needed in the resolutions campaign and urged members of The Council to have county medical societies emphasize this phase of the campaign against H. R. 4222.

### Woman's Auxiliary Legislative Conference

Mr. Nelson reported that a legislative conference will be held at the Neil House, Columbus, on April 13, sponsored by the Woman's Auxiliary to the Ohio

State Medical Association with the cooperation of the OSMA. He stated that invitations had gone out to all local auxiliary presidents to secure at least two persons from each auxiliary to attend and that a program revolving around H. R. 4222 has been arranged. The program also will contain discussions of how the doctor and his wife can participate in politics and how members of the auxiliary can assist in the legislative program of the OSMA.

### American Medical Political Action Committee

Mr. Nelson reported that he had been advised that around $9,000 has been contributed to date by Ohio physicians in response to letters sent directly to them from the AMPAC in Chicago. The Council expressed the opinion unofficially that it did not seem necessary at this time for Ohio to form a statewide American Medical Political Action Committee. It was agreed that the situation would be watched and that such an organization would be formed later if necessary. Several members pointed out that it might be advisable later to form local or district political action committees in certain areas of the state to assist qualified candidates for Congress.

### Blue Shield Program for Senior Citizens

Mr. Coghlan, Mr. Van Holte and Dr. Yantes, chairman of the OMI Executive Committee, at the request of The Council, then discussed the new National Blue Shield Program for Senior Citizens. Mr. Coghlan referred to a communication written to the Executive Secretary on March 1 on this subject and which read as follows:

"As you know, the National Association of Blue Shield Plans has developed a uniform contract, referred to as the National Blue Shield Senior Citizen Contract. It is anticipated that there will be an open enrollment period for persons over 65 years of age to enroll in this contract in spring or early summer of 1962.

"Ohio Medical Indemnity, a member Plan of the National Association of Blue Shield Plans, has been asked to participate in this national enrollment. Participation would involve Ohio Medical Indemnity paying claims on an agreed fee schedule and being reimbursed for these claim payments plus overhead expense.

"There is a provision in this National Blue Shield Senior Citizen Contract stating that if the subscriber receives service from a participating physician, and his income is less than $2,500 single or $4,000 family, the participating physician agrees to accept the payment as payment-in-full and will not charge the patient any additional amount for the service he has rendered which is provided in the contract.

"The details of this contract were received by the Executive Committee of Ohio Medical at its meeting on February 21st and, after thorough exploration, the following motion was adopted:

'that Ohio Medical Indemnity advise the Council of the Ohio State Medical Association that Ohio Medical cannot act on the National Blue Shield Senior Citizen Contract because of the mandate given to Ohio Medical Indemnity relative to the operation of a service plan in Ohio.'

"The Executive Committee discussed alternatives that might be offered in place of this national plan and is at present reviewing these alternatives."

Mr. Coghlan reported that the OMI Board is considering re-opening the enrollment of coverage in OMI to persons 65 years and over. He pointed out that after this is done it probably would be tied into the state-wide publicity and advertising program which OMI will carry on in the near future to inform the people of Ohio about the preferred and major contracts offered by OMI.

Following a lengthy discussion of this subject, The Council, by official action, adopted a motion that Ohio Medical Indemnity be instructed to prepare facts and figures for The Council as to what OMI would offer if given permission to participate in the National Blue Shield Plan for aged citizens or is authorized to compete with more liberal plans offered by other insurance companies or health care plans.

A second motion was immediately adopted, authorizing the President to call a special meeting of The Council for Sunday morning, April 29, starting at 9 o'clock, Eastern Standard Time, to consider the report from OMI with the view for possible submission of this information to the House of Delegates at the 1962 Annual Meeting.

### 1962 Annual Meeting

The Executive Secretary reported that plans are progressing satisfactorily for the 1962 Annual Meeting the week of May 14 in Columbus.

The President was authorized to appoint a committee to judge the Scientific and Educational Exhibits.

Copies of the resolutions which will be presented at the 1962 Annual Meeting were distributed to members of The Council. It was agreed that a copy should be sent to each of the following in advance of the Annual Meeting: president and secretary of each county medical society, executive secretaries and delegates and alternate-delegates. Members of The Council desiring additional copies of the resolutions for their district meetings were asked to file their request with the Executive Secretary.

### Dr. Hudson Resigns as AMA Delegate

Dr. Charles L. Hudson, Cleveland, a member of the Board of Trustees of the American Medical Association, submitted his resignation as an AMA delegate from Ohio for the term expiring December 31, 1962. Dr. Hudson pointed out that he felt

his election to the Board of Trustees of the AMA would result in a conflict of activities which would make it impossible for him to serve in both capacities. His letter of resignation extended appreciation to the OSMA for their confidence in supporting him for the high office of the AMA and pledged continued active interest in all the affairs of the Ohio State Medical Association. By official action, The Council accepted Dr. Hudson's resignation and expressed deep appreciation for his loyal and efficient service in all of the offices he has held in the Ohio State Medical Association and in his new position as AMA trustee.

The Council, also by official action, instructed the Executive Secretary to bring to the attention of the Nominating Committee at the 1962 Annual Meeting the fact that Dr. Hudson has resigned and that this vacancy for the remainder of the calendar year 1962 should be filled by the House of Delegates in addition to the election of a successor for Dr. Hudson for the new term of two years starting January 1, 1963.

### Nominees for OMI Board of Directors

Dr. Hoyt reported for the nominating committee to nominate persons for the Board of Directors of Ohio Medical Indemnity. The committee recommended that the following be nominated and elected for the ensuing year: Perry R. Ayres, M. D., Columbus; Dwight L. Becker, M. D., Lima; H. M. Clodfelter, M. D., Columbus; Mr. Clair E. Fultz, Columbus; Charles N. Hoyt, M. D., Chillicothe; Msgr. Robert A. Maher, Toledo; Mr. Edgar O. Mansfield, Columbus; Robert S. Martin, M. D., Zanesville; J. Stewart Mathews, M. D., Wyoming; Mr. Stanley R. Mauck, Columbus; Mr. J. A. Meckstroth, Columbus; Mr. Clarence O. Poleni, Cleveland; George L. Sackett, M. D., Cleveland; Mr. John Schoedinger, Columbus; L. Howard Schriver, M. D., Cincinnati; Frank L. Shively, Jr., M. D., Dayton; Mr. Harold W. Slabaugh, Akron; Robert G. Smith, M. D., Circleville; Gordon M. Todd, M. D., Toledo; Edmond K. Yantes, M. D., Wilmington; Starling C. Yinger, M. D., Springfield.

By official action, The Council approved the nominations presented and authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting of OMI in April on all business matters coming before that meeting, including the election of directors placed in nomination by The Council at this meeting on March 18, 1962: Dr. H. M. Clodfelter, Columbus, or Dr. Edmond K. Yantes, Wilmington, or Mr. Charles S. Nelson, Columbus.

### Joint Committee on General Practice

A report of the Joint Committee on General Practice was presented by Dr. Thomas E. Rardin, Columbus, chairman of the committee. By official action, The Council **approved** the report of the committee, with minor amendments, reading in part as follows:

"Following a complete review, the Committee approved, with revisions a 'Proposed Basic Program for Exposure of Medical Students to Family Practice Concepts,' which the Chairman had prepared for the Committee's consideration. (See Exhibit B)

"The Committee voted to recommend to The Council that:

"1. **Council approve the proposed basic program**, and that the program be forwarded to the deans of Ohio's three medical schools along with a letter of transmission from the President of the Ohio State Medical Association.

"2. **Council approve of transmission of a letter** from the President of the Ohio State Medical Association to the Cleveland, Columbus and Cincinnati Academies of Medicine asking that the Academies establish a Family Practice Liaison Committee in each city to work with representatives of the medical school and of the Ohio State Medical Association in implementing this proposed program.

"3. **Council approve the Committee's recommendation** that the Committee's mission not be the establishment of 'chairs' or 'departments' of general practice in the sense that they are normally thought of, but rather that the mission be to achieve medical school acceptance of the concepts contained in the proposed basic program. (Exhibit B.)

"4. **Council approve the recommendation** of the Joint Committee on General Practice that the name of the Committee be changed to Joint Committee on General (Family) Practice."

### Committee on Disaster Medical Care

Mr. Page presented a report of the Committee on Disaster Medical Care, based on the minutes of a meeting of that committee held on January 7, 1962. The report was officially **approved** by The Council.

### Joint Advisory Committee on Athletic Injuries

Mr. Page presented a report of the Joint Advisory Committee on Athletic Injuries, based on the minutes of a meeting of that committee held on December 12, 1961. The report was officially **approved** by The Council.

### Committee on Maternal Health

Mr. Page presented a report of the Committee on Maternal Health, based on the minutes of a meeting of that committee held on January 27-28, 1962. By official action, The Council **approved** the report, with the exception of a proposed third amendment to "Guiding Principles for Obstetric Care" relating to the provision as to who should be qualified to give a spinal or caudal anesthetic. This part of the report was referred back to the Committee on Maternal Health for further consideration.

### Ohio Cancer Coordinating Committee

Mr. Edgar presented a report of the Ohio Cancer Coordinating Committee, based on the minutes of a meeting of that committee held on Sunday, March 11,

1962. The report was officially approved by The Council.

### Committee on Care of the Aged

Dr. Robechek presented a report of the Committee on Care of the Aged of which he is chairman. The report was based on the minutes of a meeting of the committee held on Wednesday, March 14, 1962. The report was officially approved.

### Committee on Laboratory Medicine

Mr. Edgar presented a report of the Committee on Laboratory Medicine, based on the minutes of a meeting of that committee held on Sunday, March 4, 1962. The report was officially approved by The Council.

### Committee on Eye Care

A report of the Committee on Eye Care was submitted by the Executive Secretary. Such report, which was based on the minutes of a meeting of that committee held on Sunday, January 7, 1962, was officially approved.

### Committee on Occupational Health

The Executive Secretary submitted a report on a meeting of the Committee on Occupational Health, based on the minutes of a meeting of that committee held on January 31, 1962. This report was officially approved.

### Judicial and Professional Relations Committee

The Executive Secretary submitted a report on a meeting of the Judicial and Professional Relations Committee, based on the minutes of a meeting of that committee held on January 14, 1962. This report was officially approved.

### Committee on Hospital Relations

Dr. Orr presented a report on a meeting of the Committee on Hospital Relations, of which he is chairman. The report was based on the minutes of a meeting of that committee held on February 4, 1962 and was officially approved.

### Committee on Future Planning

A report of the Committee on Future Planning was submitted by Dr. Meiling. This committee was created in response to a resolution adopted by the House of Delegates in May, 1960, for the purpose of making a detailed study of the advisability of proceeding with plans to establish a state headquarters in an office building owned by the Ohio State Medical Association. Dr. Meiling reported that his committee had met on Sunday, February 25, to consider a lengthy report prepared for the committee by Mr. Saville and Mr. Nelson, containing voluminous data regarding the present space and facilities of the Association; the growth of the Association since 1951 and the potential growth of the Association during the next ten or twelve years; the real estate situation in greater Columbus and a list of pros and cons with respect to the ownership of a building, etc.

A detailed report was filed with the Council (see appendix to these minutes).

Dr. Meiling stated that the principal recommendation of his committee is contained in the following section of the report:

"After thorough consideration, it was the unanimous opinion of the Committee that The Council must establish a policy as to the future needs of the Ohio State Medical Association and as to whether the Association shall continue to lease office space or construct its own building.

"The following motion was then adopted:

"The Committee recommends to The Council that a policy be adopted, that by the time of the expiration of the present office lease on June 30, 1966, the Association should have control of headquarters facilities that are both adequate in size and location for at least 25 years.

"If The Council approves this recommendation, the Committee would like authority to continue its study and bring back specific recommendations to The Council."

After an extensive discussion, it was moved by Dr. Hardymon, seconded by Dr. Artman and carried, that the report and recommendations of the Committee on Future Planning be accepted and approved.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
*Executive Secretary.*

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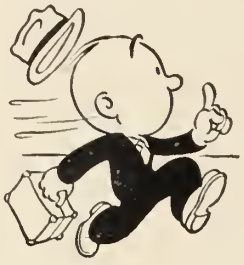
## Two New Films Highlight King-Anderson Pitfalls

The American Medical Association has announced two new films available to county medical societies for use in informing audiences about the implications of the King-Anderson Bill.

One is a 15-minute cartoon style film, "The Return of Horsehide Hooper," which describes a hypothetical situation of a young man, his family and his neighbors to bring out the consequences which ensue if this legislation were passed.

The second, "Your Right to Say It," is a 30-minute film of a television broadcast in which Ernest B. Howard, M. D., AMA assistant executive vice-president, adroitly handles questions concerning medical care of the aged under Social Security, and which leaves no doubt as to the soundness of the AMA's position.

Inquiries and requests for showing the films should be addressed to Radio, Television and Motion Picture Department, Communications Division, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.



# *Hotel Reservations?*

## Better 'Phone NOW!

## 1962 ANNUAL MEETING OF THE
## OHIO STATE MEDICAL ASSOCIATION

## May 14, 15, 16, 17, and 18
## COLUMBUS

*Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing*

| NAME AND LOCATION | SINGLE | DOUBLE | TWIN |
|---|---|---|---|
| NEIL HOUSE, 41 S. High St. (Headquarters Hotel) | $ 7.00- 9.50 | $ 9.50-12.00 | $12.00-15.00 |
| DESHLER HILTON HOTEL, W. Broad & N. High | $ 7.50-14.00 | $12.00-15.00 | $13.50-20.00 |
| PICK-FORT HAYES HOTEL, 31 W. Spring St. | $ 8.00- 9.50 | $11.00-12.00 | $14.00 up |
| HOTEL SOUTHERN, S. High & E. Main Sts. | $ 7.50- 8.00 | $10.00-10.50 | $11.00-12.50 |

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK
Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 14-18, 1962, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Other

Arriving May.....at.....A. M.....P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

# Last Call for OSMA Annual Meeting Columbus, May 14-18

FOR physicians who have not done so already, there is still time to make arrangements and attend the 1962 Annual Meeting of the Ohio State Medical Association in Columbus, May 14 - 18. Features will be in the Veterans Memorial Building at 300 West Broad Street, and the Neil House in downtown Columbus.

A storehouse of scientific presentations await Ohio physicians. Planners of the program have reached near and far to secure talent and to present a well-rounded program and schedule of events. Refer to March and April issues of *The Journal* for details as to names of speakers, subjects, titles of exhibits, and other data.

**Monday and Tuesday, May 14 and 15**

- First Meeting of the House of Delegates, Monday evening; House Reference Committee Meetings, Tuesday.

**Wednesday, May 16**

- Second Session of the House of Delegates
- General Sessions
  - Program Sponsored by the Ohio State Heart Association
  - Program Sponsored by the Ohio Chapter, American Cancer Society
- The President's Ball

**Thursday, May 17**

- General Session
  - Program under auspices of the OSU College of Medicine
- Specialty Meetings
  - Internal Medicine
  - Nervous and Mental Diseases
  - Neurological Surgery
  - Obstetrics and Gynecology
  - Ophthalmology
  - Otorhinolaryngology
- Conference on Laboratory Medicine
- Fireside Conferences
  - Sponsored by American College of Chest Physicians and Its Ohio Chapter

**Friday, May 18**

- General Sessions
  - What's New in (1) Long-Term Anticoagulant Therapy; (2) Use of Vaccines; (3) Enzymes in Diagnosis; (4) Oral Antiovulatory Agents; (5) Antibiotic Prophylaxis
  - New Drugs
  - Radiation Hazards
- Specialty Meetings
  - Anesthesiology
  - General Practice, Occupational Medicine, Physical Medicine, and Radiology (combined)
  - Orthopaedic Surgery
  - Pathology
  - Pediatrics

**Other Features**

Three Days of Scientific and Educational Exhibits — Technical Exhibits — Physicians' Art Exhibit — Special Luncheons or Other Meetings of Special Groups — Specialty Organization Meetings Extended into Saturday.

Refer to March and April issues for Complete Details

# Polio Immunization . . .

## Recommendations Issued by Director of Health on Procedures After Type III Oral Vaccine Approval

A MEMORANDUM on poliomyelitis immunization procedures, as affected by the announcement of the licensure of a Type III oral poliomyelitis vaccine, was issued April 5 by Ohio Health Director Ralph E. Dwork.

Addressed to all Ohio Health commissioners the communication announced the licensure of a Type III vaccine by the United States Public Health Service on March 28 and called attention to "Recommendations of the Public Health Service for the Use of Poliomyelitis Vaccines during the 1962 Season."

### Text of Dwork Letter

With the omission of two introductory paragraphs, the text of Dr. Dwork's letter to health commissioners is as follows:

"In some health jurisdictions, oral polio vaccine programs are already in progress; in others they will begin soon. Since there is a tendency to turn to new techniques while forgetting the old, we should like to point out that completion of an entire oral vaccine program requires at least three months, and protection against the three types of poliomyelitis viruses can be attained by oral vaccines only if all three types of vaccines are given. Type III has increased in other parts of the country and has shown some evidence of increase in Ohio. Consequently, a vaccine program insuring protection against this type of the disease is desirable this year.

### Depends on Supply and Time

"Thus if the vaccine for Type III is difficult to obtain or in short supply, it may be desirable to continue the Salk vaccine program, even though one may be planning to use oral vaccines in the future. Partial protection is obtained against all three types, even with one shot.

"Another point that should be emphasized is the desirability of carrying out an oral vaccination program primarily in the winter and in the spring, unless an outbreak erupts.

### Preferred Order of Use and Ages

"We call attention to the preferred order of use of the three types of oral vaccine, namely, Type I, followed by Type III, followed by Type II, and finally the multivalent vaccine containing Types I, II and III. This schedule should be adhered to whenever possible. Of course, exceptions will be made in those few communities which have already conducted programs with Type I and II vaccines, and in communities with an outbreak.

"The Public Health Service recommendations do not comment on the preferred age limits for an oral vaccination program. From the aspect of disease protection, the lower age limit should be between three and six months, and there should be no upper limit. For administrative reasons, some communities may want to change these limits.

### Additional Recommendations

"In each community program there should be special concern for keeping accurate records and educating the public to the need for detailed type-specific records. Never before has there been such a multiplicity of immunizing agents for one disease, or a comparable need for detailed identification of the immunizing agents.

"In conclusion, it should be emphasized that the groups with poorest immunity to polio are the preschool children and the young adult males. Therefore, any community program should be specially designed to reach these groups.

### Regarding School Admission

"Vaccination with oral vaccine will be acceptable for admission to schools. It is to be emphasized that the killed vaccine and the live oral vaccine produce immunity in different fashions and therefore, are not additive. Partial compliance with each of these alternate methods of vaccination will not satisfy school entry requirements. The complete series of one or the other technique will be required."

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## Disclosure Law To be Enforced

Food and Drug Administration officials told a meeting of drug industry officials that they intended to fully implement new FDA regulations effective March 15, requiring drug makers to list adverse effects of drugs in package inserts of drugs and in literature left with physicians.

Detail men are required to leave literature with physicians, carrying full information on drugs they are selling, the officials said.

# Big Promotional Program by OMI...

## Opens Enrollment for Senior Citizens and Tells Public About "Preferred" and "Major" Contracts

OHIO Medical Indemnity, Inc., Ohio's Blue Shield Plan which is sponsored by the Ohio State Medical Association, has launched a state-wide publicity and promotional campaign through direct mail, news articles and newscasts and advertising in newspapers, radio and television in support of the following objectives:

1. To advise Ohio residents who are now 65 or over and who are not now enrolled by Ohio Medical Indemnity, that a state-wide enrollment of 14 days, ending May 13, will give Ohio's aged citizens another opportunity to obtain Blue Shield surgical and medical cost protection.

2. To advise Ohio Medical Indemnity subscribers who are covered under the OMI "Standard Contract" that OMI has contracts — the "Preferred" and the "Major" — which offer more adequate benefits than the "Standard" and urging groups of employees and employers to seriously consider converting to one of the two better contracts. Publicity regarding the "Preferred" and "Major" contracts has not been released in the five-county Cleveland area as OMI does not underwrite in that part of the state which is covered by Medical Mutual of Cleveland.

### About the Senior Citizen Contract

Two years ago during the first enrollment period for Senior Citizens, approximately 75,000 Ohioans were enrolled. During the present enrollment period, application may be made by mail. Application blanks are appearing in newspaper advertisements. Letters have been sent to Ohio physicians, as well as posters and folders for their waiting rooms, describing both of the above mentioned programs. Physicians have been appealed to to urge patients and others to take advantage of these opportunities offered by OMI.

Important aspects of the SENIOR PREFERRED Medical – Surgical plan include these vital points: (1) No physical examination is necessary; (2) no health statement required; (3) no exclusion because of present or past health problems; (4) no waiting periods for existing conditions; no need to be employed. Under this plan, payments will be made for surgery, in-hospital medical care, anesthesia and radiotherapy, according to the schedule of indemnities listed in the contract. Cost of the coverage per individual is $2.50 per month.

### About the Better Contracts

For a very slight increase in premium cost, those persons who are members of groups now holding the Blue Shield STANDARD Contract may elect to upgrade to the Blue Shield PREFERRED or MAJOR Contracts which provide greatly increased coverage of medical - surgical costs.

"The importance of this big promotional campaign is apparent," according to Dr. George W. Petznick, President of the Ohio State Medical Association. "It offers a fine opportunity for senior citizens to obtain good medical - surgical insurance coverage, or for their relatives to secure it for them. The other part of the dual program is long overdue. OMI has two contracts which are considerably better than the old 'Standard.' This will inform those who are inadequately insured about the better contracts and encourage them to upgrade their coverage as soon as possible."

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## Inter-Hospital Lectures Scheduled in Toledo

Dr. John P. Merrill, director of the Cardiorenal Section of Peter Bent Brigham Hospital, Boston, will give the annual Inter-Hospital Postgraduate Lecture Series, sponsored by the Medical Advance Trust of Maumee Valley Hospital, Toledo, on Thursday and Friday, May 24 and 25.

The theme will be "Renal Disease and Hypertension." Lecture subjects are: Thursday, May 24 — Noon, "Current Concepts of Renal Function — Clinical Application"; 4:30 p. m., "Pathophysiology and Treatment of Acute Renal Failure"; 8:15 p. m., "Pathophysiology and Treatment of Chronic Renal Failure."

Friday, May 25 — Noon, "Transplantation of a Kidney"; 4:30 p. m., "Current Concepts of the Management of Hypertension"; 8:15 p. m., "The Etiology and Management of Edema."

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Fires and explosions constitute the only type of accident that kills more girls than boys in the school ages.

# Bow Bill Summarized . . .

## Interest Shown in Health Care Proposal For Aged Persons by Ohio Congressman

A BILL, H. R. 10981, introduced by Congressman Frank T. Bow, Canton, Ohio, on the subject of medical care insurance for persons 65 years of age or over, has attracted considerable interest among many members of Congress.

### Tax Incentives Offered

Bow's bill provides tax incentives for the purchase of private voluntary medical care insurance by or for anyone aged 65 or over, as well as Government assistance in the purchase of insurance for those aged 65 or over with limited or no Federal income tax liability.

The bill proposes to use the existing facilities of the Internal Revenue and existing insurance programs for the elderly to provide medical care.

### Two Plans

The Bow bill sets minimum requirements for medical insurance under either of two plans. The first is a plan under which all of the covered expenses are paid by the insurance carrier. There is no deductible feature such as is required in the King-Anderson bill. The second is a more extensive plan of the major medical-type, involving co-insurance not to exceed 25 per cent and a deductible feature.

A tax credit of $125, deductible from an individual's income tax, would be allowed for payment of premiums on medical care insurance by any individual aged 65 or over, a relative who purchased the insurance for an individual aged 65 or over, or an employer who purchased the insurance for a retired employee aged 65 or over.

"Either of the basic plans described in my bill can be purchased for $125 by any individual 65 or over, without regard to prior illness, on a guaranteed renewable basis," according to Congressman Bow. "It is my hope, of course, that the tax credit will offer incentive for individuals to obtain even more comprehensive coverage."

### $125 Certificates

The bill provides for the issuance of "medical care insurance certificates" by the Treasury Department to any individual whose Federal income tax liability is less than $125 and who is not covered by insurance purchased by another person in his behalf.

The certificates would be redeemable in cash for not more than $125 when presented by an insurance carrier who accepted the certificates in payment of premiums on an approved medical care policy.

### 30 Similar Bills

Apparently at the request of Congressman William E. Miller of New York, the Republican National Chairman, 30 bills like or similar to that of Rep. Bow had been introduced by April 16 by 30 different Congressmen. Five Ohio Congressmen, Donald Clancy of Cincinnati, Samuel Devine of Columbus, William Harsha of Portsmouth, Charles Mosher of Oberlin and Paul Schenck of Dayton were among the 30.

### Durno Bill

Only a little earlier in this session, another bill was introduced on this subject. It was presented by Congressman Edwin Durno (R.-Oregon), a physician.

The Durno bill H. R. 10513 would set up a National Advisory Medical Commission to investigate and recommend by January 31, 1963, the "best means of providing medical care for needy Americans over age 65." The proposal provides that "to the extent feasible" the program recommended by the commission should:

### Contents of Proposal

**First.** Be voluntary.

**Second.** Be based on free enterprise effort and administered through non-governmental insurance companies.

**Third.** Provide adequate medical care including the cost of catastrophic illness.

**Fourth.** Include a basic insurance contract stated in a concise and understandable manner.

**Fifth.** Provide that the contract be available to all qualified insurance companies on an individual or cooperative basis so as to spread participation in the plan as widely as possible throughout the country.

**Sixth.** Be financed jointly by the Federal Government, the States and the individual. The Federal contribution would be by direct appropriations by the Congress. The individual's share would be determined by his income tax payments of prior years. Thus, he would not be expected to take a pauper's oath, nor would there be any loss of dignity involved.

**Seventh.** Provide for establishment of a permanent advisory committee to maintain a continuing check on operations of the program, and to report annually to Congress on any changes it finds would help the program.



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in 1962
universal therapeutic acceptance

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SEARLE

Research in the Service of Medicine

# AMA Annual Session . . .

## Chicago's New Exposition Center Will Be Scene For the Numerous Program Features, June 24-28

OHIO physicians will find many features in store for them as they join thousands of their colleagues from this country and abroad for the 111th annual meeting of the American Medical Association in Chicago, June 24 - 28.

For the first time the convention will be held in Chicago's new exposition center offering every conceivable convenience and bringing exhibits and scientific program features into one area.

Here are features that every physician will want to consider:

- All scientific features in one building, a cross-section of every medical interest.
- More than 200 eminent scientists in the Multiple Disciplinary Research Forum.
- Eight general programs by combined specialties scheduled for the first time.
- More than 700 exhibits staffed by top researchers and expert technologists.
- Surgical innovations and symposia on live color TV and motion picture premieres.
- Special daily features representing each medical discipline — and countless other vital programs of practical value in practice.

### Examples of Special Interests

A bloodless form of brain surgery that relieves cases of tremor and rigidity will be described by Dr. Irving S. Cooper, director of the Department of Neurological Surgery, St. Barnabas Hospital for Chronic Diseases, New York City. He will give physicians a summary of his 10-year investigation comprising 2000 cases.

Another feature will be a display of specimens brought in each morning of the five-day meeting from hospitals of the Chicago area. Sixty pathologists are participating in preparation of the display headed by Dr. Samuel A. Livinson, chief pathologist of the L. A. Weiss Memorial Hospital and professor of pathology emeritus at the University of Illinois.

An interesting phase of the fresh tissue exhibit is that it evolves from a pathology exhibit first shown at Columbus, Ohio, during the 1899 session of the AMA.

Doctors who attend the meeting will have an opportunity to study nearly 400 scientific exhibits of all kinds. Furthermore, they will have a choice of hearing lectures on the scientific program in which more than 2,400 physicians will participate.

### How To Make Reservations

The entire program of the AMA Annual Meeting will be published in the May 19 issue of the *Journal of the AMA.*

Registration in advance may be made by clipping one of the coupons entitled "For Advance Registration of Physicians," and mailing it to the address indicated: Circulation and Records Dept., American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois.

Hotel room reservations also may be made through the coupon appearing in the *Journal of the AMA.* After it is filled out it should be mailed to the Chicago Convention Bureau, Suite 900, 134 North LaSalle St., Chicago 2, Illinois.

### Many Ohioans Participate

Ohio's official delegation of nine delegates and their alternates will attend the meeting and be present at sessions of the House of Delegates. Many Ohio physicians also are participating in various features of the program. The Woman's Auxiliary to the AMA is meeting in Chicago the same week as the AMA session and will provide many interesting features for the ladies.

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### Women Physicians Invited to Brunch in Chicago

The American Medical Women's Association has extended an invitation to all women physicians attending the Annual Meeting of the American Medical Association in Chicago to be guests at a brunch on Sunday, June 24. The brunch begins at 11:00 a. m. at the Essex Inn, Chicago.

"Medical Woman Power — Can It Be Used More Efficiently" will be discussed by a panel with audience participation.

Acceptance of the invitation should be sent to the American Medical Women's Association, 1790 Broadway, New York 19, N. Y.

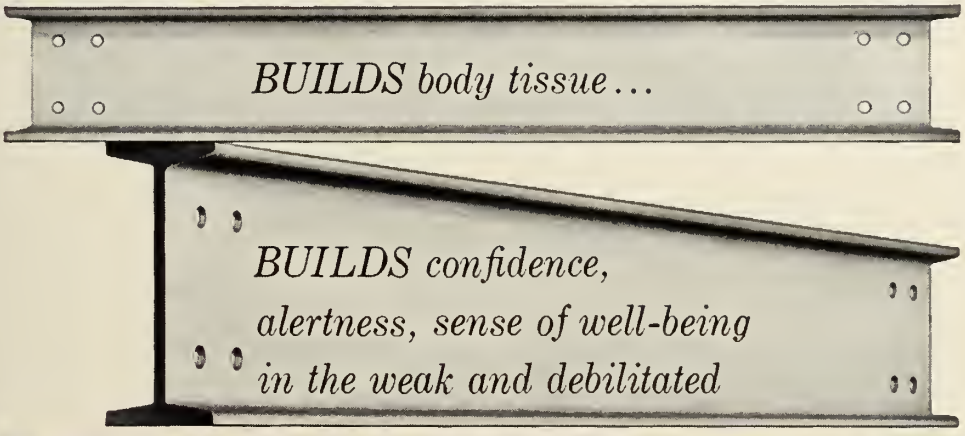
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*to treat the TOTAL patient*

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With *thirty* times the anabolic activity of methyltestosterone... and only *one-fourth* its undesirable androgenicity*—well tolerated WINSTROL therapy results in:

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for ...the tired, weak, irritable catabolic patient unable to overcome daily lethargy
...the elderly person with asthenia, inanition, anorexia or osteoporosis
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*animal data

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1671M

# Workmen's Compensation . . .

## This is the Second in a Series of Articles To Help Physicians in Their Dealings With the State Bureau

THIS is the second in a series of articles being published by *The Journal* pertaining to the administration of the Ohio Workmen's Compensation Law, especially about the rules and procedures of special interest to physicians. The articles were prepared with the assistance of James L. Young, administrator of the Bureau of Workmen's Compensation and members of his staff. The first article appeared in the April issue of *The Journal*. Clip and file these articles for quick reference. Additional articles will be published.

### What Information Should Be Included on a Fee Bill?

1. The fee bill (C-1A, C-3, OD-3, or C-19) should contain an adequate description of the injury or occupational disease including the area of the body affected, the pathology and other pertinent evidence used in the diagnosis and the relationship of the injury or occupational disease to the claimant's employer.

Examples of adequate descriptions:

A. Injury laceration, 1 inch in length, on first finger, left hand, dorsum, middle phalanx, from contact with saw blade at work.

B. Occupational disease dermatitis, on dorsum of left hand, from direct contact with epoxy resin used in occupation as a molder.

2. An estimate of the claimant's present disability, a medical substantiation of any periods of temporary disability with an estimate of such extent of disability by percentage figure and an opinion as to the extent of any permanent disability that may result.

3. The date and a brief description of each medical service or treatment provided to the claimant.

4. The actual signature of the attending physician. A signature stamp is not acceptable under this requirement.

5. The medical license number of the attending physician, necessary since the large volume of monthly fees requires the use of electronic data processing equipment and its necessary coding.

**Want A Speaker on Subject of Workmen's Compensation?**

**The Bureau of Workmen's Compensation and the Industrial Commission of Ohio will be happy to provide a speaker on Workmen's Compensation, with special emphasis on fee bills, claims procedure and related subjects. Requests should be directed to: Mr. George H. Thompson, Chief Deputy Administrator, Claims Section, Bureau of Workmen's Compensation, Columbus 15, Ohio.**

6. Any further remarks the attending physician may consider necessary to explain either the claimant's disability, the treatments provided or the fee bill submitted.

### How Does the Physician Obtain the Correct Claim Number?

The initial claim application is assigned a claim number immediately upon its receipt by the Bureau.

The named employer is notified of the assigned claim number regardless of the type of claim involved.

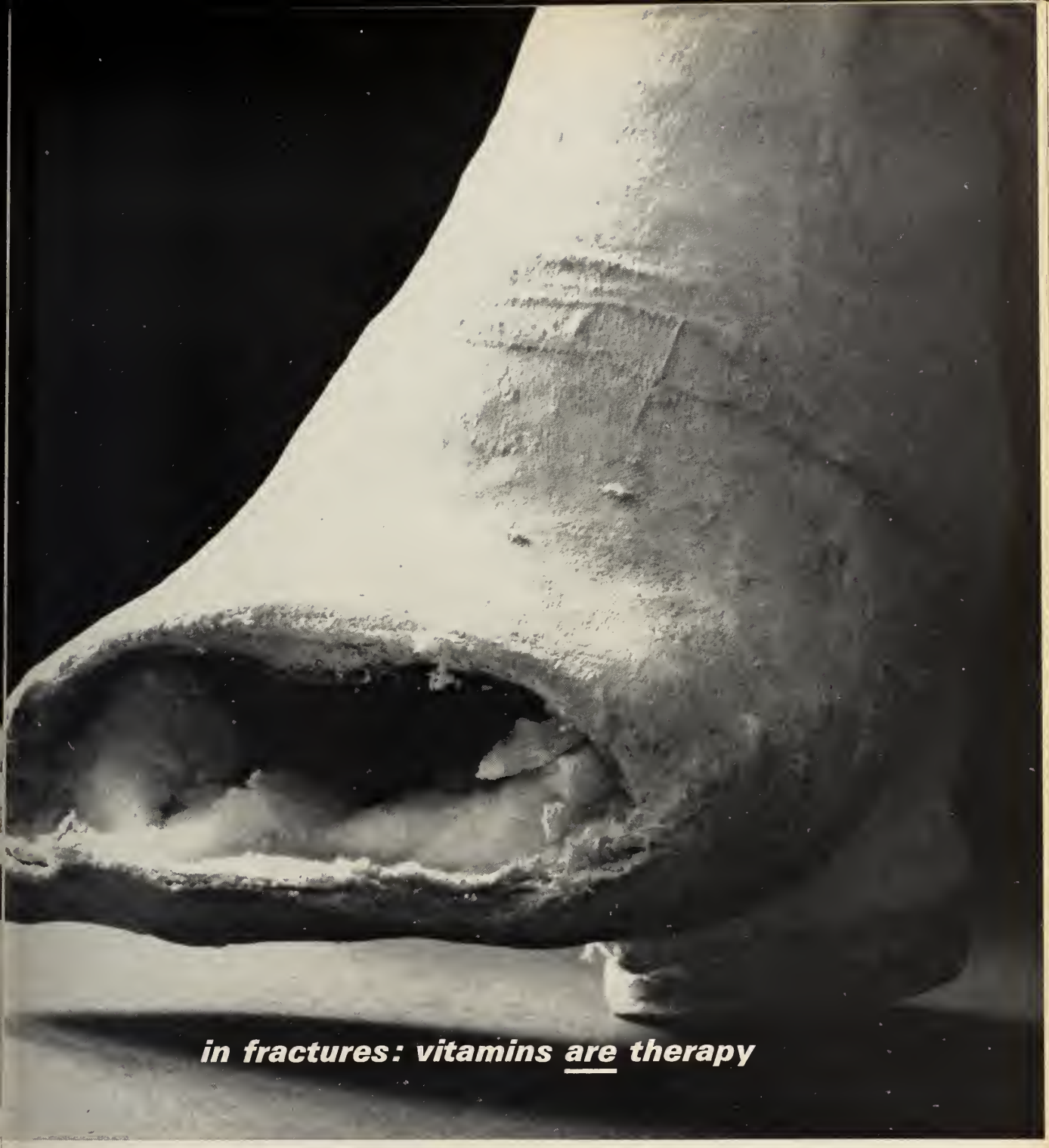
The claimant is notified of the assigned claim number only if the lost time of more than seven days from work is involved in the claim.

Suggested sequence for inquiries concerning claim numbers:

1. If lost time of more than seven days from work is involved, the claimant will receive notification of the assigned claim number.

2. If the claimant is unavailable or if the claim does not involve lost time, the employer should be contacted for the assigned claim number. (This is a good reason for the physician to include the employer's name in his original records of the case.)

3. If neither the claimant nor the employer can furnish the physician with the correct claim number, the physician should contact the Claims Section of the Bureau of Workmen's Com-




w factors are more fundamental to tissue and bone aling than nutrition. Therapeutic allowances of B and C tamins are important for rapid replenishment of vitamin serves which may be depleted by the stress of fractures. etabolic support with STRESSCAPS is a useful adjunct an uneventful recovery. Supplied in decorative eminder" jars of 30 and 100.

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| Vitamin $B_1$ (Thiamine Mononitrate) | 10 mg. |
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| Niacinamide | 100 mg. |
| Vitamin C (Ascorbic Acid) | 300 mg. |
| Vitamin $B_6$ (Pyridoxine HCl) | 2 mg. |
| Vitamin $B_{12}$ Crystalline | 4 mcgm. |
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pensation, Columbus 15, Ohio. A self-addressed post card may be included with this inquiry.

### Information To Be Included in Inquiries to the Bureau.

Any inquiry to the Bureau should include the claimant's name, the employer's name, the date of the injury, the date of the first treatment by the attending physician and a brief description of the injury or occupational disease involved.

### How Does the Attending Physician Determine If a Fee Bill Has Been Paid?

The physician should direct his inquiry to the Claims Section, Bureau of Workmen's Compensation, Columbus 15, Ohio. The inquiry should include not only the information suggested above but also the exact dates and description of the medical treatments in question.

### How To Request for Status Reports on a Particular Claim.

All requests for status reports concerning a claim should be directed initially to the local district office of the Bureau of Workmen's Compensation.

### How Soon Is a Fee Bill Ordered Paid?

If the claim is not disputed, has been certified by the employer, is adequately described, and contains sufficient medical substantiation, the fee bill is ordered paid immediately upon its review by the Bureau Claims Examiner.

If the claim application is disputed, uncertified, incomplete, or fails to meet the requirements of compensability, the payment of the fee bill is delayed pending further investigation or processing of the claim.

If the claim is disputed by the employer, the payment of medical bills is held pending affirmation of the claim by the Industrial Commission of Ohio.

### When Does the Physician Receive Payment for His Fee Bills?

Fee bills approved for payment in any given month are paid by the middle of the following month. Occasionally, fee bills will be received late in the month and cannot be processed in time to be included in the next month's remittance advice.

**(Watch for Article No. 3 in this Series.)**

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## New President Named for Polio Institute

Gerard Piel, publisher of the magazine, *Scientific American,* was elected president of the Salk Institute for Biological Studies now being built in San Diego, Calif. Announcement of the New York publisher's election was made by Dr. Jonas Salk, Institute director.

The trustees also authorized a $15 million Building Fund campaign to be sponsored from June 1 through 15 by the National Foundation-March of Dimes to give the American people an opportunity to take part in this undertaking, Dr. Salk said.

The Salk Institute will be made up of scientists of exceptional ability from many parts of the world, working together to study questions in basic biology.


## Changed Your Address? If So, Send the New One to Us Promptly

If you have moved, you will want *The Journal* and other OSMA mail mailed to your new address. Please use the coupon below to give us this information and mail the coupon to the Ohio State Medical Association, 79 E. State St., Columbus 15, Ohio, immediately as it takes several weeks to get our mailing list adjusted.

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New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

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| Isuprel® (brand of isoproterenol) HCl | 2.5 mg. |
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| Theophylline | 45 mg. |
| Potassium iodide | 150 mg. |
| Luminal® (brand of phenobarbital) | 6 mg. |
| Alcohol | 19% |

*Adult Dose:* 2 tablespoons 3 or 4 times daily.

*How Supplied:* Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

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# Foundation for Medical Care...

## New Mechanism for Handling Prepaid Activities Is Set Up in Montgomery County; Details Are Outlined

IN his inaugural address on January 12, Dr. Lynne E. Baker, the 1962 president of the Montgomery County Medical Society, described in some detail developments in that county with regard to setting up a "Foundation for Medical Care." Because such a project is new in Ohio and because it has attracted interest in many areas of the state, The Journal is publishing herewith the complete transcript of that portion of Dr. Baker's address dealing with this subject as printed in the *Montgomery County Medical Society News*. Said Dr. Baker:

* * *

"I want to discuss in some detail what I consider to be one of the most significant developments in the history of medicine in Montgomery County. It's a development that began early in 1960—received the "go ahead" sign from the Medical Society in 1961 and which we plan to implement in 1962.

"I refer to the 'Foundation for Medical Care' which was approved by the Society one month ago, on December 13, and is now in the process of incorporation.

### The Background

"Now by way of background . . . The Medical Society has for years been concerned about distribution of medical care—through the mechanism of prepaid health insurance. In the late 30's and early 40's, our members joined with physicians throughout Ohio in founding and financing Ohio Blue Shield. Our members served and continue to serve on the Board and Executive Committee. Since 1940 private carriers by the score have entered the health insurance field. As a result, the medical care consumer has available now a range of insurance coverage for medical - surgical - hospital care costs to an extent beyond our most optimistic forecasts of a few years ago.

"However, in spite of the excellent job done by the health insurance industry, doctors and patients in Dayton and Montgomery County were concerned about the extent of coverage through prepayment. We were concerned about the number of medical and surgical procedures covered and how much of the total cost of these procedures was taken care of by prepaid insurance.

### Studies Made

"In 1960, a committee was appointed to begin a study of the situation. In January, 1961, the committee was enlarged to 25 members, representing every branch of medicine in the Society. This group, under the able chairmanship of Dr. Frank L. Shively, Jr., met at least twice a month during the year except for a period of two months, when it met weekly. Consultants were called in from such places as Cleveland, Columbus, Youngstown; Anderson, Indiana and Stockton, California. A representative of the committee, Dr. Nat Hollister, spent several days in California for an on-the-spot study of prepayment programs there. Conferences were held with consumer groups.

"In the process, the committee and various subcommittees carried on an intensive study of every facet of the problem.

"It became apparent that the consumers of medical service, our patients, were tremendously interested in securing health insurance giving full coverage for a maximum number of medical - surgical procedures —those performed in the hospital and some which are done in the physician's office.

### Survey of Fees Made

"We felt that such coverage was highly desirable. The question was how to get it. A number of things had to be done before it could be obtained at all. First, there had to be predictability of cost of the procedures to be covered, before insurance carriers could write actuarily sound coverage. But costs in medicine vary by community. Dayton's costs are higher than those in rural areas—lower than those in the larger cities.

"So—the committee decided that it would try to find out what the usual fee is, at the present time—for various medical and surgical procedures in the moderate income group. We considered those with annual family incomes of $7500 or less as comprising this group.

"Upon completion of the survey of usual fees,

they will become part of a maximum fee schedule for medical and surgical services in Montgomery County, for those earning $7500 or less.

### What Is the Foundation?

"Here is where the Foundation comes in. The Foundation for Medical Care will be operated as a separate non-profit membership corporation. Members of the Medical Society can become members of the Foundation upon application. This membership must be renewed annually.

"Members of the Foundation agree to the maximum fee schedule, as a ceiling for the procedures covered. Through the Foundation medium then, insurance companies have the predictability of costs —they can write "full coverage" insurance for the most frequent procedures on the basis of the usual rate in this area. Patients can then purchase insurance giving them "certainty of coverage" and tailored to meet the needs and costs as they exist in this community.

"The Foundation schedule is available to all ethical insurance companies who desire to underwrite insurance which meets Foundation standards.

"Those companies meeting the standards—in other words those willing to write policies giving what the Foundation considers adequate—realistic protection to patients will receive Foundation sponsorship.

### Other Services

"The Foundation mechanism provides for other services. One that's highly important is its plan for review under medical supervision of every claim rendered. We feel this procedure is in the best interest of local control and responsibility.

"I am informed that our Foundation is the first of its kind in the middle west. To my knowledge, they exist at the present time in only two states—California and Oregon. There they have proven to be the best answer developed so far in setting up means for realistic budgeting for health care costs through prepayment.

"The Montgomery County Medical Society believes that its Foundation for Medical Care is the best and soundest approach toward the distribution of medical service at the most reasonable cost to the patient, the preservation of freedom of choice of physician by the patient, and the preservation of the personal physician-patient relationship. It will provide an opportunity to work in cooperation with medical service plans and the insurance industry for the development of realistic, well-designed financing mechanisms."

# Coming Meetings . . .

**American Medical Association,** Annual Meeting, Chicago, June 24-28.

**Ohio State Medical Association,** Annual Meeting, Columbus, May 14-18.

**Ohio State Radiological Society** meeting, Akron, May 25-27, Chapin Hawley, M. D., Secretary, 927 Carew Tower, Cincinnati 2.

**Ohio State Surgical Association,** Annual Meeting, Nationwide Inn, Columbus, Friday, May 11.


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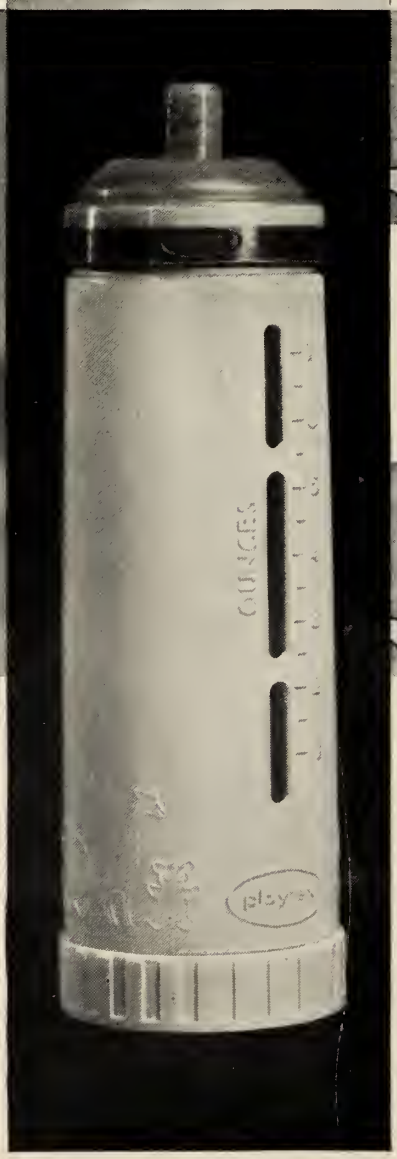
# The revolutionary discovery that simulates breast feeding.....



*Natural nursing action nipple induces even sucking that dramatically lessens outside air swallowing and makes baby exercise his jaws. Designed to avert tongue-thrusting and other malocclusions not inhibited by conventional nipples.*

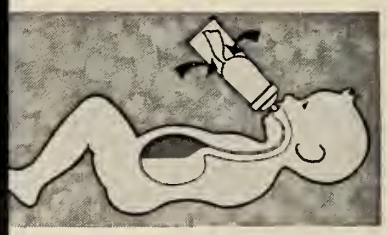


*Because the disposable bottle is pre-sterilized, it eliminates the possibility of contamination through improperly sterilized bottles.*






***With conventional bottle** air has to get inside bottle for milk to come out. Nipple often collapses and baby has to suck harder, so more air gets into his stomach. Both overfeeding and underfeeding can ensue, along with the aerophagia and flatulence which can produce colic, spitting up, and after feeding distress.*



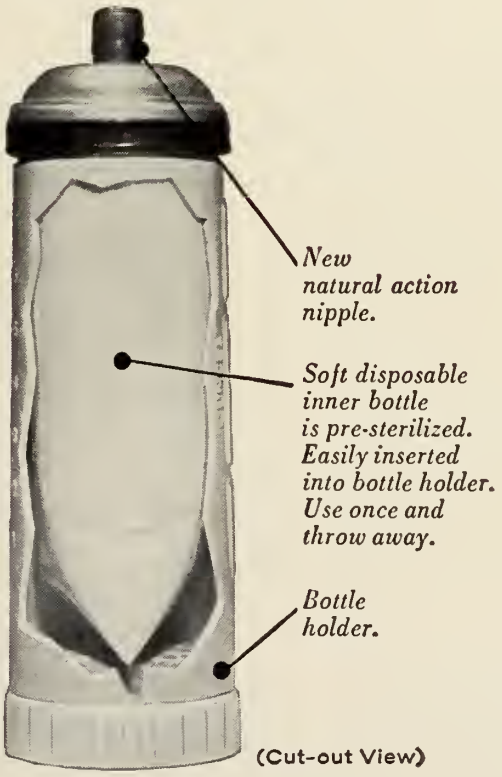
***Natural design nipple** of Playtex Nurser assures even flow. Its pliable inner bottle contracts with atmospheric pressure as formula is consumed. Baby takes more nourishing formula, less swallowed air to cause discomforting spitting up and colic.*

# dramatically reduces spitting up and colic

To the members of the medical profession who recognize the advantages of breast feeding—here's a completely new concept in baby feeding that all doctors will welcome. The new Playtex Nurser. It features a soft, pre-sterilized inner bottle which is disposable, and a broad, non-collapsing nipple which produces a sucking action similar to that in breast feeding.

Because the outside atmospheric air pressure contracts the soft inner bottle, the formula is withdrawn more naturally than with conventional rigid baby bottles. There is no vacuum formation to set up air blocks. The natural-action nipple induces sucking which makes for less air swallowing, and less spitting up—and in so doing, promotes the healthful mouth-jaw exercises the mother's breast provides.

Colicky infants, problem feeders and premature babies especially will benefit from the breast-like action of the new Playtex Nurser. The fact that the bottle is pre-sterilized and disposable will appeal to mothers who do not breast feed their babies. The fact that the Nurser does so closely simulate breast feeding will be similarly important to the health of any baby fed with it.




(Cut-out View)

*"Nature's Way"*

# PLAYTEX NURSER

*"The nearest approach to breast feeding"*

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In Our Opinion

# Comments on Current Economic, Social And Professional Problems

### "FUNDS FOR MEDICAL SCHOOLS" PROJECT GETS EARLY START

Recently Ohio physicians received a letter on behalf of the American Medical Association's Education and Research Foundation requesting a contribution to the "Funds for Medical Schools" project. This letter marks the beginning of the 1962 campaign to provide unrestricted grants to medical schools.

Last year, AMA-ERF distributed $1,300,000 to medical schools across the country as a result of this campaign. This was accomplished through the efforts of the physicians of the U. S., both individually and through their local societies and woman's auxiliaries. Ohio set a record-breaking pace in that campaign. $63,200 was contributed by 2,073 donors.

Again this year, this is a project worthy of your vigorous support. Stronger medical schools will be your reward.

Don't confuse this project with the successful AMA-ERF Loan Guarantee Program for medical students, interns, and residents announced earlier this year. All physicians were also asked to contribute to that Fund. Many have already responded. The contributions now total more than $350,000 making more than $4,250,000 available for loans.

Both of these projects are worthy of the support of all doctors.

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### INTERESTING REACTIONS TO YOUNGSTOWN AD

"Medical care for all, regardless of ability to pay." This is the belief of the Mahoning Medical Society as expressed in an advertisement appearing in the *Youngstown Vindicator*. This strong feeling that no person in Mahoning County should go without medical care simply because they cannot pay for it is not a new feeling. It is one that many doctors everywhere subscribe to. The general public, however, is often unaware of it.

As a result of this frequent lack of knowledge, the doctors of Mahoning County took positive action and the reaction is interesting to note.

Seven phone calls were received. One of these was an emergency and was given immediate attention. The other six were given equal attention, but in every case, the caller had made no attempt to obtain medical care for himself. None, therefore, had been refused medical care.

Only one call came from a person over 65. Of the others, one was able to pay for medical care, one proved to have no need for a doctor's attention, and one failed to keep his appointment . . . after it was made for him.

Does this indicate a certain reaction to "free" medical care? Does it further suggest that perhaps most of the elderly of that county and also of our state are able to pay for their own medical care without the helping hand of government? We believe it does.

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### TELLING THE PATIENT ALSO HELPS THE PHYSICIAN

Too often this patient complaint is heard: "But, the doctor won't tell me anything about what he's doing and why." Physicians such as these certainly could improve their physician-patient relationship were they to follow the advice laid down by Dr. Leandro M. Tocantins, professor of clinical medicine, Jefferson Medical School, in an address to the 1961 entering class at Jefferson. Said Tocantins:

"In your future practice, you will discover that an essential part of your service to the patient is what you tell him concerning his disease, and what you are attempting to do to correct it. Often, in making this attempt, you may discover that the problem becomes a little clearer to yourself. In a lecture when he left the University of Virginia in 1833, Dunglison said that: 'As a general principle, explain freely to your patient, if intelligent and if he desires it, the grounds on which you proceed in the management of his case. If you cannot do this, there will generally be good reason for supposing that your comprehension of the case is not as clear as it ought to be.'"

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### STEVE WRONG AGAIN; LABOR SPENDING TOPS AMA

Recently, Ohio's junior U. S. Senator, Stephen Young, was quoted in a Washington UPI dispatch as calling the AMA the "spendingest" lobby in Washington.

As usual, Young is 100 per cent wrong.

The record, which apparently he did not consult, shows that the AMA spent $163,404 in 1961 and that all of the registered labor unions spent a total of $1,024,049.28 for lobbying, including $706,961.79 by the AFL-CIO unions alone. The figure for labor

lobbying does not include expenses of registered lobbyists for 17 unions, including some big ones like the United Automobile, United Steelworkers, and United Mine Workers unions.

The figures are taken from reports filed with the Clerk of the House of Representatives by organizations registered under the Federal Lobbying Act.

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### WHAT TO DO WITH YOUR RECORDS WHEN YOU MOVE

When a physician leaves a community to practice elsewhere what should he do with patients' records? This puzzling question is well answered by Edwin J. Holman of the Law Department of the AMA, as follows:

"When leaving a community, a physician is under no obligation to turn his records over to his patients. He should not, however, indiscriminately dispose of these records. In many instances, the patient must rely on his physician's records in order to establish the fact that he did receive medical care and treatment or that he had had the services of a qualified doctor of medicine. Without his records the physician who rendered the care would be unable to assist his patient. Furthermore, it is possible that the records might be of value to the patient's succeeding physician. From a selfish point of view, the physician would be well advised to save his records as a safeguard against possible malpractice actions until the statute of limitations has run to obviate this need. His records would be essential in developing a defense to a malpractice action brought against him. When a physician contemplates moving from a community, he might notify the patients on his active list of the fact that he intends to leave and encourage the patients to seek the services of some other doctor. He could also suggest that, with the patient's consent, arrangements can be made to permit a succeeding physician, designated within a reasonable time by the patient, to review these records. In this way the patient's best interest will be served."

### NATIONWIDE THINKS H. R. 4222 IS OK

Those who are working to defeat the King-Anderson-Kennedy Bill, H. R. 4222, are not getting support from a group of Ohio's biggest insurance companies, believe it or not. On the other hand, it may not be surprising to some.

In his report to stockholders for the year 1961, Murray D. Lincoln, president of the Nationwide Insurance Companies, has this to say:

"Nationwide — among the major insurance companies of the nation — supports the social security approach to medical care for people over 65, and has supported this approach for two years."

After telling why Nationwide has taken this stand and how it is participating in an experimental program in Connecticut to provide insurance coverage for persons 65 and over, Lincoln concludes:

"But Nationwide still believes that a proper balance of effort on the part of industry and government is needed to achieve a program that will provide for every citizen's health needs in his old age, and that private insurance will have a broader, sounder market for voluntary insurance if it builds on basic government provisions."

Obviously, the right of Lincoln and Nationwide to express their views and act accordingly is conceded. Whether or not they are correct is a matter of opinion. As Lincoln states in his report — with pride — Nationwide is known as a "controversial" organization.

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### RESULTS WILL GET APPLAUSE

In our opinion a move in the right direction is being undertaken by a newly-created advisory committee on pharmaceutical nomenclature, formed by the AMA and U. S. Pharmacopeia organization. It will try to simplify the nonproprietary names of ethical drugs. The medical profession undoubtedly will loudly applaud any practical results emerging from the conferences now being held.




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*Supplied:* Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

*Usual Adult Dosage:* 1 or 2 capsules three or four times a day.

*Side Effects:* Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

*Warning:* Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

*TRADEMARK, REG. U. S. PAT. OFF.
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# Ohio State Surgical Meeting, May 11

Ten medical college professors, two United States Congressmen, an insurance company executive, a medical academy president and the father of the well-known Marshall (medical) plan will speak at the Ohio State Surgical Association's annual meeting Friday, May 11, at Nationwide Inn, Columbus.

At 9 a. m., Drs. William T. Fitts, Jr., clinical professor of surgery, University of Pennsylvania, Peter V. Moulder, Jr., assistant professor of thoracic surgery, and Joseph P. Evans, professor of neurological surgery, both of the University of Chicago, will discuss the patient with multiple traumata.

This trio will be joined by Drs. James K. Stack, assistant professor of orthopaedic surgery, Northwestern University, F. M. Woolhouse, professor of plastic surgery, McGill University, Montreal, and Jack N. Taylor, associate professor of urological surgery, Ohio State University.

At 10:45 a. m., Drs. Fraser Gurd, professor of surgery, McGill University, James C. Drye, professor of surgery, University of Louisville, and Marion S. DeWeese, associate professor of surgery at the University of Michigan will be joined by Drs. Moulder and Taylor in a discussion of abdominal surgery.

The afternoon program will begin at 1:45 with a discussion of "Third Party Medicine."

Members of the panel will be Dr. Mathew Marshall, Jr., Pittsburgh, Dr. Donald Sweeney, Jr., president of the Detroit Academy of Medicine, and Mr. Robert Rennie, vice-president of Nationwide Insurance Company, Columbus. Dr. Stephen W. Ondash, Youngstown, immediate past-president, will moderate.

At 3:30, a trio of individuals will tackle the topic, "The Doctor and Politics." Representative Frank T. Bow, Canton, is the author of a medical care plan now pending. Both he and the other two panel members, Representative John Ashbrook, Johnstown, Ohio, and Joe E. Miller, Chicago, executive director of the American Medical Political Action Committee, are strong opponents of the Kennedy-sponsored King-Anderson bill.

A candlelight dinner will be held in the evening. Wives are invited.

## Report Shows Progress on Hill-Burton Program

In the second half of 1961, 202 projects were approved for Hill-Burton financial aid. They provide for 9,407 inpatient beds (6,565 general, 1,106 mental, and 1,736 for long term care) and 20 public health centers, 15 diagnostic/treatment centers and 11 rehabilitation facilities. From the program's actual beginnings in 1948 through the close of 1961, 5,888 projects have been approved with total estimated cost of $5,131,245,000. Of this amount, the Federal share was $1,624,174,000.

Obituaries

# Ad Astra

Alfred Adler, M. D., Mansfield; Medical Faculty of the University of Frankfurt-am-Main, Prussia, 1932; aged 58; died March 20; member of the Ohio State Medical Association, the American Medical Association, American College of Chest Physicians and the American Trudeau Society. A native of France, Dr. Adler practiced in Germany and France before World War II. After coming to this country he interned at Iowa State Sanatorium and later did work at Benjamin Franklin Tuberculosis Sanatorium and at Ohio State University. He had been superintendent of the Richland Hospital since 1951. A member of several Masonic bodies, he is survived by his widow and two daughters.

Paul Gebhard Albrecht, M. D., Winter Park, Fla. (formerly of Cleveland); University of Illinois College of Medicine, 1924; aged 76; died March 27; former member of the Ohio State Medical Association; member of the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. Dr. Albrecht retired in 1955 and moved to Florida after practicing in Cleveland for about 30 years. A native of Germany, he came to this country in 1911 and was educated in the U. S. and abroad.

Stephen Austin Edwards, M. D., Van Wert; Miami Medical College, Cincinnati, 1907; aged 83; died March 15; member of the Ohio State Medical Association, American Medical Association, American Academy of Ophthalmology & Otolaryngology; Fellow of the American College of Surgeons; diplomate of the American Board of Otolaryngology. Dr. Edwards practiced for many years in Van Wert after moving there from the Middle Point community in 1923. He retired in 1957. Active in civic affairs, he was associated with many local organizations such as the YMCA, the Van Wert Clearing House, Community Chest and Rotary Club. As a veteran of World War I, he was a member of the American Legion and belonged to the Masonic Lodge and the Presbyterian Church. Survivors include his two sons, Dr. G. A. and Dr. T. L. Edwards, both of Lima; also two daughters.

Mildred Been Fertman, M. D., San Francisco, Calif.; Ohio State University College of Medicine, 1945; aged 45; died March 13. Dr. Fertman was the wife of Dr. Manuel H. Fertman and practiced with her husband in Cleveland before the couple moved to California. She was recently on the staff of Stanford University Medical School. Surviving in addition to her husband are three children and her mother.

Stephen Wilfred Goldcamp, M. D., Youngstown; Jefferson Medical College of Philadelphia, 1907; aged 78; died March 2; member of the Ohio State Medical Association and the American Medical Association. A native of Ironton, Dr. Goldcamp took internship training in Youngstown and remained there to practice for more than a half century. His practice was in the field of EENT. Two members of the family were associated with him in practice, a brother, Dr. John Goldcamp and a son, Dr. Richard Goldcamp. Surviving also are another son, five daughters, another brother and a sister.

Charles Goosmann, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1903; aged 80; died March 14; member of the Ohio State Medical Association, the American Medical Association, American Roentgen Ray Society and the American Radium Society. Before his retirement seven years ago, Dr. Goosmann practiced for many years in Cincinnati where he was radiologist at Deaconess Hospital. Surviving are his widow, two sons, two sisters and two brothers.

Ella Gertrude Lupton, M. D., Gallipolis; Woman's Medical College of Pennsylvania, 1894; aged 99; died March 21; member of the Ohio State Medical Association and the American Medical Association. A native of Gallipolis, Dr. Lupton returned there to practice after receiving her medical degree. She later took graduate work at the Toledo State Hospital, in the East and in England. Her pioneer efforts in behalf of local projects and her participation in civic affairs were many. In addition to her practice, she served on the County Board of Health, the County Tuberculosis and Health Association and the Business & Professional Woman's Club. She taught a class in the local Presbyterian Church, belonged to the WCTU and was a leader in the woman suffrage movement. Surviving are a brother and a sister.

Loyd Hufty Marshall, M. D., Cortland; Medico-Chiurgical College of Philadelphia, 1907; aged 88; died March 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Marshall practiced medicine for some 36 years in Cortland and vicinity. His early practice was in Pennsylvania and for a few years before moving to Cortland he practiced in California. Surviving are his widow and a son.

William Muhlberg, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1897; aged 86; died April 6; member of the Ohio State Medical Association, the American Medical Association and the American Diabetic Association. A physician in Cin-

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cinnati for many years, Dr. Muhlberg was long associated with the Union Central Life Insurance Company, and was active in health association work in many areas. He was past-president of the Cincinnati Board of Health, the Cincinnati Heart Council, the Public Health Federation and the American Association of Medical Directors. He was formerly on the faculty of the University of Cincinnati College of Medicine. Surviving are his widow and a daughter.

**Harry Garfield Nelson,** M. D., Cincinnati and Fort Thomas, Ky.; Medical College of Ohio, Cincinnati, 1906; aged 82; died March 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Nelson practiced for many years in the Cincinnati area before his retirement in 1951. He is survived by his widow and a sister.

**Norman Stewart Reed,** M. D., Caldwell; University of Pittsburgh School of Medicine, 1910; aged 77; died March 26; member of the Ohio State Medical Association and the American Medical Association; 1962 president of the Noble County Medical Society. Dr. Reed moved his practice to Caldwell in 1937 after previous residence in Cleveland. For many years he was Noble County coroner and health commissioner. A veteran of World War I, he was a member of the Presbyterian Church and the Masonic Lodge. Survivors include his widow, a son, a daughter, a sister and a brother, Dr. C. L. Reed of Pittsburgh, Pa.

**Robert Wilson Schilling,** M. D., Toronto; Ohio Medical University, Columbus, 1901; aged 84; died April 4. Health commissioner for Jefferson County for the past nine years, Dr. Schilling's practice of medicine extended over a half century, and included areas of Jefferson, Columbia and Carroll Counties. His widow and a daughter survive.

**Kenneth P. Scott,** M. D., Newark; Ohio State University College of Medicine, 1928; aged 61; died April 6; member of the Ohio State Medical Association and the American Medical Association. A native of Lancaster, Dr. Scott began practice in Elyria, later moved to East Palestine and located in Newark in 1947. At the time of death he was serving as Licking County coroner. A member of the Methodist Church, Dr. Scott is survived by his widow and a daughter.

**Earl Stanley Simmonds,** M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1907; aged 79; died April 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Simmonds practiced medicine for more than a half century, principally in the Cheviot and Western Hills area of Greater Cincinnati. A member of the Methodist Church and the Masonic Lodge, he is survived by a son, a daughter and two brothers.

**Ernest James Snyder,** M. D., Akron; Ohio State University College of Medicine, 1931; aged 57; died March 4; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Akron, Dr. Synder returned there to practice in 1937. He was a member of the Christian Church and several Masonic bodies. Surviving are his widow, his mother, a brother and a sister.

**James Burton Street,** M. D., Cincinnati; University of Cincinnati College of Medicine, 1950; aged 45; died April 6; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Street had been inactive professionally for about eight years because of illness. Surviving are his widow, a son, a daughter and his parents.

**Jack Merrill York,** M. D., Perry; University of Buffalo School of Medicine, 1929; aged 56; died March 20; member of the Ohio State Medical Association, the American Medical Association, American College of Chest Physicians and the Industrial Medical Association. A native of Lake County, Dr. York returned there to practice. He was physician for the Diamond Alkali Company before World War II and after the war became full-time medical director. From 1942 to 1946 he was in military service. Affiliations included membership in the Congregational Church and several Masonic bodies. Surviving are widow, a son, a daughter, two sisters and three brothers.


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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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# ANNUAL AUDIT OF BOOKS OF OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL FOR YEAR ENDING DECEMBER 31, 1961, BY LYBRAND, ROSS BROS. & MONTGOMERY, CERTIFIED PUBLIC ACCOUNTANTS

## OHIO STATE MEDICAL ASSOCIATION

| | | |
|---|---|---|
| **Cash, Bonds, Savings Accounts on Hand, January 1, 1961** | | |
| Cash in Huntington National Bank: | | |
| Accumulated unexpended income for 1960 | $ 73,182.91 | |
| 1961 Exhibit payments collected in 1960 | 7,220.00 | |
| Total | 80,402.91 | |
| Cash in Ohio National Bank: 1961 Membership dues and accrued interest | 74,905.37 | |
| U. S. Treasury and Savings Bonds | 65,000.00 | |
| Savings Accounts (3) | 33,272.33 | |
| Total Cash, Bonds, Savings Accounts | | $253,580.61 |
| **RECEIPTS** | | |
| Interest on U. S. Treasury and Savings Bonds | 2,056.84 | |
| Interest on Savings Accounts | 4,025.06 | |
| 1961 Membership dues collected in 1961 | 198,765.00 | |
| 1962 Membership dues collected in 1961 | 81,367.50 | |
| 1961 Exhibit space collected in 1961 | 11,175.00 | |
| 1962 Exhibit space collected in 1961 | 5,471.50 | |
| Banquet tickets | 1,720.00 | |
| Payment for collection of American Medical Association dues | 1,982.13 | |
| Maturity of U. S. Savings Bond, Series G | 10,000.00 | |
| Miscellaneous: Checks cancelled; insurance premium refund | 268.85 | |
| Total Receipts | | 316,831.88 |
| **Total To Be Accounted For (Includes 1962 dues and exhibit payments collected in advance)** | | $570,412.49 |
| **DISBURSEMENTS** | | |
| The Ohio State Medical Journal | $ 38,500.00 | |
| Executive Secretary, salary | 19,000.00 | |
| Executive Secretary, expense | 1,075.80 | |
| Administrative Assistant, salary | 11,100.00 | |
| Administrative Assistant, expense | 2,095.42 | |
| Stenographic and clerical salaries | 41,546.50 | |
| President, expense | 3,387.20 | |
| President-Elect, expense | 585.72 | |
| Council expense | 5,677.90 | |
| American Medical Association Delegates | 7,332.73 | |
| Dept. of Public Relations: | | |
| Director, salary | 16,500.00 | |
| Director, expense | 1,114.88 | |
| Assistant Director, salary | 12,600.00 | |
| Assistant Director, expense | 2,429.38 | |
| Exhibits and newspaper publicity | 202.41 | |
| Literature | 689.74 | |
| Postage | 2,253.47 | |
| Supplies | 756.83 | |
| Miscellaneous Activities | 2,790.19 | |
| Standing Committees: | | |
| Education | 482.11 | |
| Judicial and Professional Relations | 268.89 | |
| Scientific Work | 660.75 | |
| Special Committees: | | |
| Auditing and Appropriations; Bookkeeping | 985.00 | |
| Cancer | 97.34 | |
| Care of the Aged | 1,115.32 | |
| Hospital Relations | 375.13 | |
| Laboratory Medicine | 674.94 | |
| Maternal Health | 1,283.42 | |
| Mental Hygiene | 95.85 | |
| Miscellaneous | 845.67 | |
| Occupational Health | 387.23 | |
| Rural Health | 1,673.76 | |
| School Health | 2,930.20 | |
| Annual Meeting | 24,661.79 | |
| Conference County Society Officers | 1,801.42 | |
| Councilor District Conferences | 3,259.22 | |
| Emergency and Equipment Fund | 5,641.06 | |
| Employees' Retirement Fund | 7,033.33 | |
| Bonding, Insurance, Social Security Taxes | 4,852.25 | |
| Lectures for Senior Medical Students | 1,956.19 | |
| Legal Expense | 16,547.35 | |
| Library | 320.27 | |
| OSMAgram | 4,113.27 | |
| Postage | 2,610.00 | |
| Professional Relations Activities | 6,217.77 | |
| Rent and Utilities | 12,577.32 | |
| Rural Medical Scholarships | 2,000.00 | |
| Stationery and Supplies | 5,977.54 | |
| Telephone and Telegraph | 3,720.17 | |
| Woman's Auxiliary Contribution | 1,500.00 | |
| Refunds: Dues and exhibit deposits | 360.00 | |
| Pension Trust, Huntington National Bank | 40,000.00 | |
| Purchase and interest on U. S. Savings Bond, Series H | 10,117.86 | |
| Total Disbursements | | 336,780.59 |
| **Cash, Bonds, Savings Accounts on Hand, December 31, 1961** | | |
| Cash in Huntington National Bank: | | |
| Accumulated unexpended income | $ 15,825.14 | |
| 1962 Exhibit payments collected in 1961 | 5,471.50 | |
| Total | 21,296.64 | |
| Cash in Ohio National Bank: | | |
| 1962 Membership dues and accrued interest | 82,803.61 | |
| U. S. Treasury and Savings Bonds | 65,000.00 | |
| Savings Accounts (6) | 64,531.65 | |
| Total Cash, Bonds, Savings Accounts | | 233,631.90 |
| **Total Accounted For** | | $570,412.49 |

## THE OHIO STATE MEDICAL JOURNAL

### ASSETS

| | | |
|---|---|---|
| **Current Assets:** | | |
| Cash in Ohio National Bank | | $ 1,464.54 |
| Petty Cash | | 30.00 |
| Accounts Receivable: Net Advertising | | 11,122.21 |
| Postage Deposit | | 160.00 |
| Total Current Assets | | $ 12,776.75 |
| **Property Assets:** | | |
| Furniture and equipment, depreciated value | | 19,668.63 |
| **Total Assets** | | $ 32,445.38 |

### NET WORTH

| | | |
|---|---|---|
| Net Worth, December 31, 1960 | $ 39,461.38 | |
| Less: Overexpended income for year | 7,018.50 | |
| | $ 32,442.88 | |
| Deferred advertising income | 2.50 | |
| **Total Net Worth, December 31, 1961** | $ 32,445.38 | $ 32,445.38 |

### STATEMENT OF PROFIT AND LOSS

| | | |
|---|---|---|
| **Income:** | | |
| Advertising, gross | | $ 79,291.88 |
| Less: Commission on advertising | $ 9,849.99 | |
| Cash discount on advertising | 634.66 | 10,484.65 |
| Advertising, net | | $ 68,807.23 |
| Ohio State Medical Association appropriation | | 38,500.00 |
| Ohio State Medical Association equipment | | 1,531.14 |
| Subscriptions and sales | | 1,048.49 |
| Total net income | | $109,886.86 |
| **Expenses:** | | |
| Salaries | $ 24,855.00 | |
| Journal printing | 81,810.56 | |
| Journal postage | 1,424.22 | |
| Stationery, printing, and supplies | 3,809.37 | |
| Illustrations and engravings | 2,076.56 | |
| Travel expense | 215.97 | |
| Depreciation | 2,085.23 | |
| Miscellaneous postage | 398.26 | |
| Miscellaneous expense | 230.19 | |
| Total expenditures | | $116,905.36 |
| **Net Loss for the Year** | | $ 7,018.50 |

# Activities of County Societies...

## First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

### HAMILTON

Dr. Richard L. Varco, professor of surgery at the University of Minnesota College of Medical Science, spoke before the March meeting of the Academy of Medicine of Cincinnati on the subject, "Principles and Practice in the Care of the Clean Surgical Wound." The program was presented in cooperation with The Cincinnati Surgical Society.

### HIGHLAND

The Highland County Medical Society recently recommended to the community through the press that continued use be made of Salk polio vaccine. It further announced that the Society will submit a planned program for use of oral vaccine at such time as is practical and after all three types of vaccine are available commercially.

## Second District

(COUNCILOR: RAY M. TURNER, M. D., SPRINGFIELD)

### MIAMI

Dr. Bertha A. Bouroncle, associate professor of medicine at Ohio State University, spoke on "Recent Treatment of Leukemia and Lymphomas" at the March meeting of the Miami County Medical Society held at the Piqua Country Club.

### MONTGOMERY

The 32-voice glee club of the Montgomery County Medical Society presented a varied program of classical music, operatic excerpts and Broadway show tunes recently at the Dayton Art Institute. Dr. W. J. Lewis is director of the glee club which is made up of Dayton area physicians.

Dr. J. M. Albrecht, Dr. Chin Woo Imm, Dr. Stanley Garber, Dr. S. J. Randall and Dr. J. H. Muehlstein were soloists.

## Fourth District

(COUNCILOR: EDWIN R. MURBACH, M. D., ARCHBOLD)

### LUCAS

The April meeting of the Academy of Medicine of Toledo and Lucas County consisted of the presentation of papers by the residents of Toledo hospitals and awards presented by the Maumee Valley Hospital Medical Advancement Trust Fund.

### SANDUSKY

The Sixth Annual Clinic Day, sponsored by the Sandusky County Medical Society, was presented on April 25 at the Fremont Yacht Club. The program included a talk on "The Present Status of Chemotherapeutics in the Treatment of Malignant Disease," by Dr. Francis E. Bull, instructor in internal medicine at the University of Michigan.

Also presented were: a talk on "The Prenatal and Postnatal Management of Rh Incompatibility," by Dr. David G. Anderson, instructor in obstetrics and gynecology at the University of Michigan, and a talk on "Pathological and Physiological Basis for the Management of Diabetic Acidosis," by Dr. Robert D. Johnson, associate professor of internal medicine, University of Michigan.

## Fifth District

(COUNCILOR: HENRY A. CRAWFORD, M. D., CLEVELAND)

### CUYAHOGA

The Academy of Medicine of Cleveland in cooperation with the Scientific Council of the Cleveland Area Heart Society presented a two-part meeting on April 25. The afternoon session was devoted to three panel discussions on the topics "Surgery in Congenital Heart Disease," "Surgery in Rheumatic Heart Disease," and "Surgery in Arteriosclerotic Heart Disease." Particular emphasis in all three talks was placed on "Diagnosis, Indications, Contraindications and Results."

At the evening session, Dr. Charles K. Friedberg, director of cardiology and attending physician, Mt. Sinai Hospital, New York City, and associate clinical professor of medicine, Columbia University, spoke on "The Current Status of Cardiac Surgery."

## Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

### COLUMBIANA

The Columbiana County Medical Society met recently at the Wick Hotel in Lisbon to hear Dr. William Ford of Pittsburgh speak on the subject, "Cardiovascular Surgery." The results of the recently concluded program of Sabin I vaccine were also discussed.

### MAHONING

One hundred and thirty physicians and attorneys attended the Eighth Annual Medical-Legal Banquet sponsored by the Mahoning County Medical Society.

The speaker was Dr. Leonard L. Lovshin, head of

the department of internal medicine of the Cleveland Clinic. He presented a humorous address on "The Professional Man's Problem — How to Live with Ambition, Fatigue and Stress."

The role of host for this annual affair alternates each year between the medical society and the Mahoning County Bar Association. The banquet was held at the Mural Room restaurant and Dr. C. W. Stertzbach, president, presided.

Dr. Jack Schreiber spoke briefly on the King-Anderson Bill, and pamphlets concerning the bill, as well as directions for writing to congressmen, were distributed to all physicians and attorneys present.

### SUMMIT

The March meeting of the Summit County Medical Society was held at the Akron Tower Motor Inn. This meeting was preceded by dinner attended by some 53 members and guests. When the meeting was called to order by President McDonald, an additional 90 some members were present.

Dr. William Marsh introduced the speaker, Dr. Eldred B. Heisel, professor of dermatology at the Ohio State University College of Medicine. He spoke on the subject of "Mucocutaneous Lesions — the Windows to Systemic Diseases." His talk was illustrated by colored slides.

* * *

"The Sick, the Nervous, the Worried" was the topic for discussion by a panel of four at the April meeting of the Summit County Medical Society held at the Akron Tower Motor Inn.

Participating in the panel were Rev. G. Carlan Elliott, Rev. Donald L. Powers, Dr. James R. Hodge and Dr. John P. Schlemmer. The panel was moderated by Dr. William H. Holloway.

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

### BELMONT

Dr. Russell V. Lucas, instructor in the pediatric department of West Virginia University School of Medicine, spoke before the April meeting of the Belmont County Medical Society on the topic "Common Congenital Defects of Infancy."

## Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, ZANESVILLE)

### FAIRFIELD

The Fairfield County Medical Society met recently at Shaw's Restaurant and heard a varied program on Civil Defense, radioactive fallout and a speech on doctor-patient relationships.

Arthur Bartlett, public health educator of the county health department, discussed his position of publicizing the health department, working with school health education and presented the emergency "self-help" kit for national disaster which has been initiated by the AMA.

Dr. James Beesley delivered an interesting address on patient-physician relationships, pointing out what patients could and should expect from their attending physicians, and what physicians had a right to expect from the patients they treat.

## Ninth District

(COUNCILOR: CHESTER H. ALLEN, M. D., PORTSMOUTH)

### SCIOTO

At the April meeting of the Scioto County Medical Society, Drs. Wagner and Blume spoke on the subject, "Documentations of the Medical Traveler."

## Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

### FRANKLIN

The April meeting of the Academy of Medicine of Columbus and Franklin County was held in cooperation with the Columbus Bar Association at the Regency Room of the Pick-Fort Hayes Hotel. This was the fifth annual cooperative meeting of the two groups.

Following a "mock trial" and a buffet dinner, the guest speaker, Dr. Howard D. Fabing, Cincinnati, spoke on "Epilepsy and the Law."

* * *

WBNS-Radio, Columbus, started a new concept in radio programming on March 19, designed to appeal to the mature mind. This new program entitled "Open Mike" features a 10 to 15 minutes presentation by a guest authority on some subject which establishes the theme for discussion and consideration. The remainder of the program is devoted to a question and answer period.

The Trustees of the Columbus Academy of Medicine Educational Foundation agreed to participate in this program and provide a physician guest speaker each Friday. Dr. Ronald J. Vincent serves as chairman of a radio committee to coordinate the planning and will be assisted by Dr. Olan P. Burt.

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

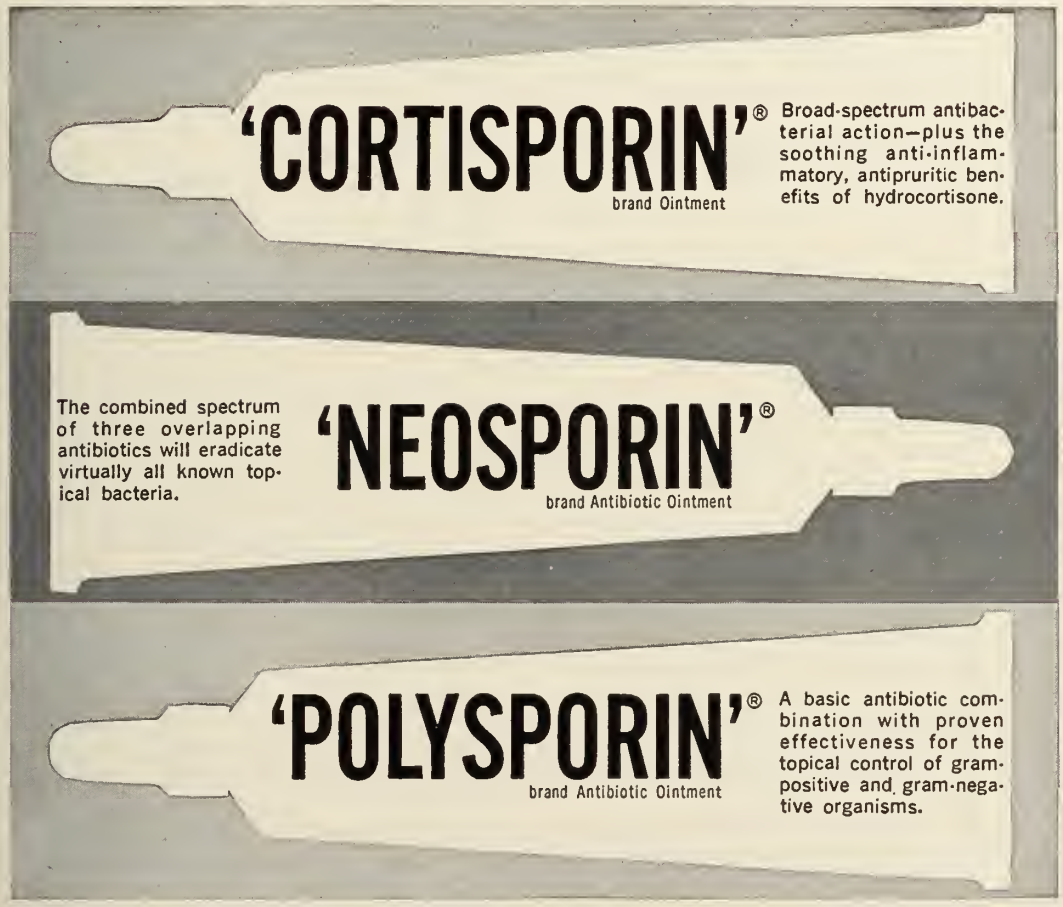
### LORAIN

Dr. Raymond W. Mack, chairman of Northwestern University's Sociology Department, was the featured speaker at the March meeting of the Lorain County Medical Society. Dr. Mack's subject was, "The Independent Professional and the Welfare State."

* * *

Forty-two members attended the regular meeting of Lorain County Medical Society on April 10 in the Oberlin Inn. Simultaneous committee meetings were held followed by the social hour and dinner.

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| Hydrocortisone | — | — | 10 mg. |
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Dr. Roy E. Hayes presided at the meeting which was reserved for Medical Society business and committee reports and activity.

The Civil Defense Committee (chairman, Peter J. Ferrato, M. D.) reported on the extensive planning with law enforcement and other agencies of the area for a Mock Alert to be held Wednesday, June 20. The hospitals will co-operate and all physicians were urged to participate.

The Maternal and Child Health Committee (chairman, J. A. Cicerrella, M. D.) presented to the membership information on Sabin oral vaccine mass immunization programs. The membership voted to conduct such a program in Lorain County in the fall, and the Maternal and Child Health Committee and the Public Relations Committee (D. A. Radefeld, M. D., chairman) will work with health departments of the county and others in planning.

Committee reports were received from Traffic Safety (Wm. L. Hassler, M. D., chairman), School Health (Franklin H. Schaefer, M. D., chairman), Liaison with County Welfare (R. A. DeMarco, M. D., chairman), Insurance (John W. Wherry, M. D., chairman) and Grievance (A. J. Piraino, M. D., chairman).

The membership voted that senators should be advised of their disapproval of the legislation now being considered, by which 20 per cent would be deducted at the source from the earnings of savings depositors, stock holders, etc.

Delegates and alternates requested that members read through the resolutions as they appear in *The Journal,* and contact them with any suggestions. The membership approved support of resolution on "Inclusion of Laboratory Services under Blue Shield Contracts."

Following a poll of the membership the Lorain County Medical Society Blue Cross group will arrange to upgrade coverage and to have dependents to age 23, included.

The Fifteenth Annual Medical Symposium will be held Wednesday, May 9th, at Oberlin Inn, with a team from Rochester University School of Medicine Atomic Energy Project presenting a program on "Radiation — Hazards and Treatments." In addition to residents and interns of hospitals in the county, hospital administrators and certain key personnel will be invited to share this timely program.

Dr. L. C. Meredith, 11th District Councilor, brought information on AMPAC and activity against H. R. 4222.

### RICHLAND

The dining room of Mansfield General Hospital was the site of the March 15th meeting of the Richland County Medical Society. After a meal of Cornish Hen, the Society adjourned to the Gayle Rife Auditorium to hear Dr. Harold Harris, chief of the E. N. T. Section of the Cleveland Clinic, who presented a talk on "Surgical Management of Deafness."

Dr. Harris stated that deafness is a very common affliction, with 10 per cent of the population being so handicapped.

Dr. Karl Kuehne, president, presided over the business meeting. The Board of Censors had previously approved the applications of Drs. Lewis L. Reese, Mansfield, Edward Grant Dowds of Shelby, and John F. McHugh of Shelby. These were presented and unanimously approved for membership by the Society.

A letter from Dr. Harry Wain, health commissioner, was read, concerning the results of the questionnaire sent to the members of the Richland County Medical Society on the proposed cancer survey in the County. Results are incomplete at this time.

A letter from John Ashbrook, Congressman from the 17th District, was read, in response to the Resolution adopted by the Society in opposition to HR 4222.

Dr. Charles Curtiss, chairman of the Auditing Committee, reported that the financial records of the Society for the year 1961 were found to be in satisfactory condition.

Dr. Robert Ellison made the motion that the secretary-treasurer of the County Society be bonded for $5000.00 and that the office secretary be bonded for $1000.00. This motion was unanimously approved. Dr. Frank Wadsworth then made the motion that the President appoint a three man Finance Committee to assist the Secretary-Treasurer in making decisions concerning expenditures. This motion, likewise, was approved.

Dr. George Loesch gave a short report on the activities of the Public Relations Committee, especially with respect to opposition to HR 4222. Future plans to use newspaper advertisements and spot announcements on the local radio station met with Society approval. The motion by Dr. Wadsworth, that the Society appropriate $350.00 for use by the Public Relations Committee, was approved.

Dr. Karl Kuehne and Dr. Carroll Damron reported on some of the comments and literature on HR 4222 available from the County Officers meeting held in Columbus in February. The meeting was adjourned on the note of mounting enthusiastic support of more active county participation in the opposition to the King-Anderson Bill.

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Dr. Theodore S. Heineken, of Glen Ridge, N. J., first vice-president of the American College of Gastroenterology, recently assumed the office of president when Dr. Louis Ochs, Jr., resigned for health reasons. The president-elect, Dr. Edward J. Krol, of Chicago, will assume the presidency at the October annual meeting.

# Intravenous Therapy By Nurses . . .

## Statement of Policy on Subject Adopted By Eight Organizations. Including OSMA

ROLE of the professional nurse in the administration of intravenous therapy has been given extensive study during the past year at conferences sponsored by the Ohio State Nurses Association.

As a result a joint statement on the subject has been adopted by the official bodies of each of the following organizations: Ohio State Nurses Association, Ohio State Medical Association (December, 1961 meeting of The Council), Board of Nursing Education and Registration, State Medical Board, State Department of Health, State Department of Mental Hygiene and Correction, Ohio League for Nursing, and Ohio Hospital Association.

### Text of Statement

Following is the text of the joint statment, carrying the official endorsement of the foregoing organizations:

There does not appear to be anything in the Ohio Law regulating the Practice of Nursing (Sec. 4723.06) or the Medical Practice Act (Sec. 4731.34) which prohibits the nurse from performing intravenous therapy nor the physician from delegating this responsibility to her. In view of these facts and because intravenous therapy has become increasingly valuable in the treatment of patients and thus much more common in its use, we urge that individual agencies which permit their professional registered nurses to administer intravenous therapy use the following recommendations as a guide in developing their policies:

"1. The nurses be informed that any statement of policy made by professional organizations or by the employing agency does not clear the individual nurse of responsibility for her own acts. This statement will not provide immunity (from legal action) if the nurse is negligent. However, such statements will give the nurse support by setting forth specific information which these responsible groups recognize to be proper practice and sound procedure.

### Proper Training and Supervision

"2. The nurse performing this procedure shall have been properly trained and supervised until she is sufficiently competent to perform on her own. It is recommended that this be done through regular in-service educational programs for professional registered nurses. It is further recommended that consideration be given by the professional nursing schools to include this procedure in the curriculum.

"3. The physicians be informed that they must prescribe the treatment for a specific patient and that the individual physician has the obligation to decide in each instance whether or not this procedure can be safely performed by a nurse.

### Procedures In Writing

"4. The employing agency (or employer), with the assistance of the medical and nursing staff, establish in writing and disseminate the following information:

"a. The names and strengths of fluids and medications that professional registered nurses may administer intravenously.

"b. The names of those nurses who have successfully completed the training program and are competent to administer intravenous therapy.

"c. The types of patients and the areas to be used by nurses when giving intravenous therapy. It is recommended that this be limited to adult patients and in the more common veins. It is *not recommended* that nurses administer intravenous therapy to children* and infants nor in the scalp veins. "*This age group to be determined by each individual institution.")

"d. The procedure be limited to administration via venapuncture only. Nurses should not perform acts of minor surgery such as cut-downs."

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## Wiseman Memorial Is Established

The Department of Medicine in the Ohio State University College of Medicine has established the Bruce K. Wiseman Memorial Lectureship in honor of its late chairman.

Dr. James V. Warren, chairman of the department, reported that the first Wiseman Memorial Lecture was given recently in the Health Center by Dr. Carl V. Moore, former dean of the Washington University School of Medicine at St. Louis and now the chairman of its department of medicine. His topic was "Current Developments in Iron Metabolism and Hypochromic Anemia."




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Out of the Blue

# The Doctor's Proprietorship in Ohio Medical Indemnity

By R. DEAN DOOLEY, M. D.
Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

DURING a recent hospital lounge meeting, a young physician asked in response to my statement that Ohio Medical Indemnity is his insurance company: "If O. M. I. is my insurance company, please tell me how I may acquire a feeling of proprietorship?"

This leads me to believe that too many physicians are unaware of their true relationship to O. M. I. and do not know about the avenues open to them for relaying questions, comments and criticisms to those administering O. M. I.

The Ohio State Medical Association owns Ohio Medical Indemnity, Inc. Actually, O. M. I. is under the direct control of the Ohio State Medical Association through its Executive Council. The Council nominates a Board of Directors of Ohio Medical Indemnity which, in turn, is responsible to that body for the operation of O. M. I. The first line of communication with O. M. I. by a member of the Ohio State Medical Association is through his District Councilor. Your problem will be passed on by the Councilor through established channels to the responsible authorities. Reports of the Ohio Medical Indemnity activities are made periodically to The Council of the Ohio State Medical Association and I am certain they are well informed and acutely interested in the operational effectiveness of this important activity for which they are responsible.

## Direct Communications

The second, and most direct, line is communication with Ohio Medical Indemnity, either to the executive heads or the Physicians' Relations Department. The letter you write will be referred to the appropriate department for study and response. Matters relating to professional affairs, not resolved by administrative action, are referred to the Medical Advisory Committee for critical professional analysis and judgment. The Medical Advisory Committee is a large committee composed of all specialties selected from most geographical areas of the State and has been extremely cooperative with the Ohio Medical Indemnity staff.

Each county society has an appointed member, with the larger societies having two, to the Liaison Committee of Ohio Medical Indemnity. The Liaison Committeeman is the local representative of O. M. I. in his respective county organization. He is immediately informed of new developments at O. M. I. by special communication and regular newsletters. He is urged to give reports at monthly medical society meetings on the material which is mailed to him and is expected to serve as a communicating link between his local medical colleagues and the O. M. I. office in Columbus. Most emphatically, any physician is welcome to discuss O. M. I. problems with him and if he cannot supply the answer the subject will be referred to us for study and response.

Every member of the Ohio State Medical Association occupies a definite position of proprietorship in his relation to O. M. I. He indeed has many employees to serve him — employees who are specialists and competently equipped to render expert assistance. Every physician in Ohio has a definite stake in Ohio Medical Indemnity and, in turn, is vitally important to its operation.

## Individual Attention

The office of Physicians' Relations was instituted three years ago for the specific purpose of establishing a system of workable communications between O. M. I. and the physicians of Ohio. We are available at all times to supply information to individual physicians on their request. We stand ready to meet with individuals or organized groups of physicians. We at all times welcome the comments and suggestions of physicians and shall do our utmost to transmit them to the proper departments for action.

Are Ohio physicians the proprietors of Ohio Medical Indemnity? Indeed you are. Ohio Medical Indemnity stands ready to heed your bidding and translate your wishes into actions within the limits of sound insurance practices.



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Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

*References:* 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

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## Summary of Polio Cases In Ohio Last Year

Reported cases of polio in Ohio dropped to 42 in 1961. Of these, 33 were paralytic, including 4 deaths, and 9 were non-paralytic, a report from the Ohio Department of Health indicates. Table shows the total number of cases, deaths, and paralytic status of cases for the last 3 years.

*Polio Cases and Deaths Reported in Ohio 1959-1961*

| Year | Total Cases | Paralytic | Non-Paralytic | Death |
|---|---|---|---|---|
| 1959 | 267 | 169 | 86 | 12 |
| 1960 | 112 | 89 | 23 | 6 |
| 1961 | 42 | 33 | 9 | 4 |

Approximately 65 per cent of the 33 paralytic cases had not received vaccine against polio. None of the four fatal cases had been vaccinated. Nearly half of this non-vaccinated group were under 5 years of age. The ages of the fatal cases ranged from 24 to 40 years.

Preliminary national figures, reported by the Communicable Disease Center in Atlanta, show a total of 1327 cases of polio in 1961. The number of paralytic cases was 864. This represents a 66 per cent decrease in paralytic cases and a 58 per cent decrease in total cases compared to the final figures in 1960.

## Chest Physicians Plan Meeting In Chicago

The American College of Chest Physicians will hold its five-day annual meeting at the Morrison Hotel, Chicago, June 21-25. Meeting dates overlap those of the American Medical Association Annual Session and some joint programs are scheduled.

On Monday, June 25, there will be a joint meeting between the American College of Chest Physicians and the American Medical Association at McCormick Place, Chicago's new convention center. This program will include, in addition to the regular scientific sessions, six Round Table Luncheon sessions and will deal with such topics as Surgical Treatment of Acquired Cardiovascular Diseases, Special Problems in Diseases of the Chest, and Inhalation Therapy.

Fireside Conferences, again part of the joint meeting with the AMA, will be at the Morrison Hotel. Topics included in the thirty round table sessions are: Bronchial Carcinoma, Bronchitis and Pneumonitis, Emphysema, Cardiac Surgery, Myocardial Infarction, and The Smoking Controversy.

For additional information, write Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11.

Battelle Memorial Institute in Columbus recently dedicated its new $800,000 auditorium to serve as a center for scientific, educational and cultural activities of the area as well as a conference-lecture hall for the institute and its staff. The main hall seats 600.


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# Activities of Woman's Auxiliary . . .

CHAIRMAN, PUBLICITY COMMITTEE — Mrs. F. M. Wadsworth, 35 Pinecrest, Mansfield, Ohio.
(Roster of Officers, Page 632)

### ALLEN

Woman's Auxiliary to the Lima and Allen County Academy of Medicine met March 20 for lunch at the Milano Club. Hostesses were Mrs. A. W. Pinkerton, chairman, Mrs. S. J. Novello, Mrs. F. D. Rodabaugh, Mrs. C. L. Blumstein, and Mrs. R. L. Holladay.

The program was in charge of the club's Rural Health Committee composed of Mrs. F. D. Rodabaugh, chairman, Mrs. M. A. Mulvania, and Mrs. H. G. Deerhake. Their guest speaker was Mr. Gene Crawford, deputy health commissioner of Lima and Allen County, who spoke on "Health Department Activities and Responsibilities."

After discussing the history and scope of public health in the area, Mr. Crawford said that recent added responsibilities include helping state mental health program (public health nurses do follow-up on patients released from mental hospitals); combatting air pollution; a new Home Safety Program; and an Alcoholism Program which is being planned to help alcoholics in the community.

### COLUMBIANA

Woman's Auxiliary to the Columbiana County Medical Society cooperated 100 per cent to assist the Doctors in their program of dispensing Sabin oral vaccine to all the schools and 12 stations throughout the county. Auxiliary members distributed posters in every community and supplied and supervised the lay volunteers to help carry the program. A total of 53,000 people were given Type I vaccine March 21st and 24th. Type III was scheduled to be given late in April and Type II in May, at which times members will again assist.

Mrs. A. Simpson, president, directed efforts and appointed a chairman for each town. The following were Mrs. A. Fisher, East Liverpool; Mrs. J. Lauva, Wellsville; Mrs. Bonastelli, Calcutta; Mrs. P. Ringsmith, Hanoverton; Mrs. L. Pritchard, Columbiana; Mrs. P. Conrad, Leetonia; Mrs. A. Falkenstein, Salem; and Mrs. P. Cibula, Lisbon.

### CUYAHOGA

At the March 26 meeting of the Woman's Auxiliary to the Academy of Medicine of Cleveland and Cuyahoga County delegates to the annual meeting in Columbus in mid-May were announced.

Mrs. James Wychgel gave an interesting talk on "Early American Pressed Glass." Our meeting also attracted Mrs. Edward Bauman, president-elect of Ohio State Medical Association Auxiliaries.

At the meeting members contributed a considerable amount of sports equipment and the board voted an additional $100.00 for the purchase of recreation equipment, all to be donated to the State Mental Hospitals.

Mrs. James Wychgel, through the courtesy of the Cleveland Automobile Club, presented a 10-minute colored film "Broken Glass" to launch a program on safety belts. The Woman's Auxiliary is co-operating with the Women's Division of the Mayors Traffic Safety Education Committee in a "Seat Belt Crusade." Two thousand doctors are receiving Rx-for-Safety prescription pads endorsing the use of seat belts in dosage of one per each occupant of every car. The Woman's Auxiliary is also co-operating with the Junior Chamber of Commerce in making its seat belt installation campaign.

Mrs. Mason F. Sones, Jr., is chairman of safety and is assisted in this promotion program by Mrs. J. K. Potter, Mrs. James Wychgel, and Mrs. C. A. Colombi.

The Daffodil Luncheon sponsored by the Health Museum Redevelopment Fund held March 19 was well supported by our president and members of the Woman's Auxiliary.

The National Health Forum, held March 20 to 23 in Cleveland, at which many of our members volunteered hours of service, attracted the National Auxiliary president, Mrs. Harlan English, president-elect Mrs. William G. Thuss, and Mrs. Edward Bauman.

Many volunteer hours were also spent by members on the door-to-door Health Fund Drive.

Mr. Robert Lang's speech class is now over and the 30 participating members have received their diplomas and are qualified to go out and speak before civic groups.

### FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society met for luncheon March 12 at the home of Mrs. John Edwards. Mrs. Donald B. Nichols and Mrs. L. H. Urling assisted the hostess.

The President, Mrs. Jack Kraker, conducted the business session and appointed a nominating committee consisting of Mrs. James Beesley, Mrs. Charles Clark and Mrs. George Jones.

Mrs. Richard Welsh, legislative chairman, urged the members to write to their congressmen to inform them of their support for the Kerr-Mills program and their opposition to Federal intervention in medicine as proposed in the King-Anderson type legislation.

In reporting for the Health Careers chairman, Mrs. William Jasper told the group that the High School



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. said I wasn't fighting all the time. People at
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students were enthusiastic about their work in the Future Nurses' Club and that many of them have already decided to make nursing their profession, and have been accepted in various schools.

Mrs. Andrew Essman, as project chairman, gave her report, and a discussion followed in connection with the next project for the Auxiliary.

### HAMILTON

"Wheel of Fashion" was the title of the Fashion Show presented by Henry Harris for the March 20 luncheon meeting in the Netherland Hilton Hotel, with Mrs. Henry Harris as commentator. Mrs. Coith was program chairman for the day with Mrs. Trufant her vice-chairman. Hospitality chairman was Mrs. A. W. Erb with Mrs. Charles Hoyt as vice-chairman.

A comprehensive questionnaire has been sent to members by Mrs. George Balz to determine the amount of time available for volunteer projects and just which projects are most appealing to Auxiliary members. From this information a volunteer bureau will be set up next year to meet the need for community projects.

Twenty-two new members, who have joined since November 1, were welcomed at an orientation meeting at the home of Mrs. Harry L. Fry on March 20. Mrs. Fry was assisted by Mrs. William P. Jennings.

The Choral Group presented a program of folk songs during the cocktail and supper hour for the Altrusa Club's seventh annual auction and fair on March 23. Proceeds of the festivity benefitted the Downtown Senior Citizens Center.

Climax of the Legislative Workshop meetings was the dinner meeting held on March 8, in conjunction with the Academy of Medicine. During dinner each table's discussion centered around effective means of defeating the King-Anderson bill. Dinner was followed by a panel discusion. Dr. John Cranley's topic was "The Door to Socialized Medicine Is Open." Mr. Richard H. Peake, Jr., director of public affairs at General Electric, spoke on "The Labor Lobby." Dr. and Mrs. D. J. Griffin closed the meeting with a discusison of methods of political effectiveness in Hamilton County.

### HURON

Mrs. Richard Jackson gave an informative talk entitled "Hypnosis in Medicine and Dentistry" at the March meeting of the Woman's Auxiliary to the Huron County Medical Society. Mrs. Jackson spoke of the value of hypnosis and its limitations as an anesthesia or a therapeutic agent.

The home of Mrs. Thomas Eaton of Greenwich was attractively appointed for the dessert meeting.

Mrs. T. H. Smith, District Eleven director, reviewed a recent meeting she attended with the Medina County Auxiliary.

### LUCAS

The Woman's Auxiliary to the Toledo and Lucas County Academy of Medicine held February and March meetings at the Academy Library. Mrs. Howard Schaffer, director of the Volunteer Bureau of Toledo Council of Social Agencies, gave an inviting talk on "Your Potential as a Volunteer." She outlined the function of the volunteer bureau service and told of their need for volunteers in all phases of work. In keeping with the Valentine theme, members modeled one hundred years of "Sweet Valentine Styles of Yesteryear." Mrs. Franklin Earnest and Mrs. Hugh Webb were luncheon chairmen for the February luncheon meeting.

The March dessert meeting was the annual Auxiliary Invitation and had as guests women from other city and county organizations. Dr. Leonard Lovshin, head of the Department of Internal Medicine at the Cleveland Clinic, was guest speaker. His topic was "The Tired Mother Syndrome."

The Academy Blood Bank Program and Family Life Education are two auxiliary projects that have received enthusiastic participation. Mrs. Joseph Hertzberg, blood bank chairman, announced that the program achieved 100 per cent of its 1961 goal. Thanks go to the donor doctors, their wives and families who made this possible. Mrs. John Buck and her committee have been busy distributing announcements of the pre-parent series of lectures to the Toledo area doctors' offices. The series of lectures being offered again this spring by popular request is co-sponsored by the Auxiliary and Family Life Program of Toledo Schools.

A Valentine theme was used for Academy-Auxiliary dinner dance held February 3 at Bancroft Hall. Mrs. Henry Cook and Mrs. Robert Walker were chairmen for the evening of dining and dancing. Mrs. Jerry Draheim, her committee, and some artistic husbands were responsible for the comic Valentine decorations. Proceeds from the evenings enjoyment are marked for the AMEF Fund.

### SCIOTO

More than 200 attended the benefit fashion show and luncheon sponsored by the Woman's Auxiliary to Scioto County Medical Society.

The style show by Marting's followed the luncheon at James Dicky Post, American Legion Hall.

The invocation was given by Mrs. Louis R. Chaboudy, president of the Auxiliary.

Robert Appel was the fashion coordinator and piano music was presented by Mrs. Claude Estepp.

Mrs. Chaboudy announced that proceeds from the affair will be used by the Auxiliary at the present time for a student in nurses' training, but sometime in the future, the fund could be used in other areas included in health careers. Mrs. Chaboudy explained that the roll call of health careers covers 156 job opportunities.

Mothers and children were models in the show. Since the 50th birthday anniversary of the Girl Scouts is being celebrated new Scout uniforms were modeled.




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pHisoHex is available in unbreakable squeeze bottles of 5 oz. and 1 pint—and in combination package with pHisoAc Cream.

1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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## Ohio Orthopaedic Society Functions May 18 - 19

The Ohio Orthopaedic Society is co-sponsoring and sponsoring three functions in Columbus on Friday and Saturday, May 18 and 19: (1) It is sponsoring jointly with the OSMA Section on Orthopaedic Surgery the program on Friday afternoon, May 18 as part of the OSMA Annual Meeting; (2) It is holding its annual banquet on Friday evening beginning at 6:30 p. m., and (3) it is sponsoring a program on Saturday, May 19 at the Stouffer's University Inn, 2900 Olentangy River Road, Columbus, beginning at 8:00 a. m.

Refer to March issue of *The Journal,* page 345 for the Friday afternoon program.

The Saturday program has been announced as follows:

### Saturday Morning

"Two Presentations of Complicated Hip Fractures," Dr. A. R. Smith, Columbus, followed by discussion.

"Osteotomy for the Hip," Dr. Herbert Knodt, Columbus. Discussion.

"Visualization of the Hip Joint by Xero-Radiography," Dr. Bill Keiger, Columbus, followed by discussion.

"Management of Gas Gangrene," Dr. Fred Elder, Columbus. Discussion.

"Avulsion Fractures of the Os Calcis," Dr. William Patterson, Columbus. Discussion.

Tribute to Dr. Albert Freiberg, Dr. Theodore Vinke, Cincinnati.

"Whither Orthopaedics," Dr. Philip D. Wilson, New York City.

### Saturday Afternoon Program

"The Neuropathic Hip Joint with Secondary Infection," Dr. William S. Smith, Columbus, followed by discussion.

"Spondylolisthesis in Childhood," Dr. Genner, Wright Patterson Air Force Hospital.

"Rhizotomy in Spondylolisthesis," Dr. W. T. Kubiac, Columbus.

"Spondylolisthesis" (Movie), Dr. Ben R. Wiltberger, Columbus.

Discussion of three papers on Spondylolisthesis.

Two Case Presentations: (1) Aneurysm of the Femoral Artery; a Complication Following Internal Flexation of the Hip Fracture; (2) Osteochondroma-Chondrosarcoma, Dr. Richard Slager, Columbus. Discussion.

"The Reversed Tibial Bone Graft in Fracture with Nonunion," Dr. Duane D. Kackley, Columbus. Discussion.

Second executive session at 3:30 p. m.


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General Practice Review, One Week, October 8
Advanced Electrocardiography, One Week, June 18
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WASHINGTON—Clarence E. Ash, President, Marietta Memorial Hospital, Marietta; Tuathal P. O'Maille, Secretary, Marietta Memorial Hospital, Marietta. 2nd Wednesday, monthly.

### NINTH DISTRICT

GALLIA—Norman W. Pinschmidt, President, The Gallipolis Clinic, Gallipolis; Thomas P. Price, Jr., Secretary, The Holzer Clinic, Gallipolis. Last Thursday, monthly.

HOCKING—John W. Doering, President, 42 N. Spring St., Logan; Howard M. Boocks, Secretary, Court House, Logan. Called meetings.

JACKSON—John M. Cook, President, Oak Hill Hospital, Oak Hill; Brinton J. Allison, Secretary, Court House, Jackson. Called meetings.

LAWRENCE—Ralph F. Massie, President, 408 Washington St., Ironton; George Newton Spears, Secretary, 2213 South Ninth St., Ironton. Called meetings.

MEIGS—Joseph J. Davis, President, 306 N. 2nd St., Middleport; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy. Called meetings.

PIKE—Robert M. Andre, President, Lake White, Rt. 2, Waverly; Kenneth Wilkinson, Secretary, 330 E. Main St., Waverly. 1st Tuesday, monthly.

SCIOTO—Spencer W. Miller, President, 1021 9th St., Portsmouth; William E. Daehler, Secretary, 1004 24th St., Portsmouth. 2nd Monday, monthly.

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FRANKLIN—Richard L. Fulton, President, 1211 Dublin Rd., Columbus 12; Mr. William Webb, Jr., Executive Secretary, 79 E. State St., Columbus 15. 3rd Monday, monthly, except May, June, July and August.

KNOX—Delbert C. Schmidt, President, 205 East Chestnut St., Mt. Vernon; Richard L. Smythe, Secretary, Medical Arts Bldg., Mt. Vernon. Usually 1st Wednesday, monthly.

MADISON—Sol Maggied, President, 15 E. Pearl, West Jefferson; Charles Terrill Hay, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

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PICKAWAY—Francis W. Anderson, President, 416 E. Main St., Circleville; Edward L. Montgomery, Secretary, 108 Scyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Swank, President, 172 E. Main St., Chillicothe; David McKell, Secretary, 60 Central Center, Chillicothe. 1st Thursday, monthly, except June, July and August.

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HURON—John V. Emery, President, Box 269, Willard; Nino M. Camardese, Secretary, 12 Benedict Ave., Norwalk. 2nd Wednesday, every other month.

LORAIN—Roy E. Hayes, President, Elyria Medical Arts Bldg., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 214 Elyria Block, Elyria. 2nd Tuesday, monthly.

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The Fort Steuben Academy of Medicine and the Committee on Trauma of the American College of Surgeons held the joint annual trauma symposium on April 10 with dinner in the Fort Steuben Hotel, Steubenville. The subject, "Lumbar Spine," was discussed by Dr. James K. Stack, professor of orthopedic surgery, Northwestern University.

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# Classified Advertisements

Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

ATTRACTIVE OFFICE FOR GENERAL PRACTICE with x-ray and dark room. Good hospital near by. Close to Cleveland - Akron - Youngstown. Will rent or sell outright on land lease contract. This community is planning to build a shopping center almost across the street from this office. Box 259, c/o Ohio State Medical Journal.

EXCELLENT OPPORTUNITY for anyone interested in General Practice in pleasant community of 1,000 population (40 miles northwest of Dayton); house-office combination with equipment; no other doctor in town; reasonable price. Available immediately. Box 199, c/o Ohio State Medical Journal.

OFFICE SPACE FOR RENT due to death of physician. Established practice for 40 years. Ten miles to Dayton or Middletown hospitals. Community 3000 population. Will rent or lease office completely furnished with all equipment. Patients records also available. Box 236, c/o Ohio State Medical Journal.

WANTED: General surgeon, Board certified or qualified, to join three man general practice group in northern Minnesota. Excellent hunting, fishing, and skiing in the area. Associated with large specialty group in nearby community. Very active practice with some industrial medicine. New hospital facility completed 1960. Unusually liberal partnership agreement. Contact Mr. Allen G. Farley, East Range Clinic, Virginia, Minnesota.

EXCELLENT COLUMBUS OPPORTUNITY: Location at 2675 W. Broad St., at present occupied by internist for 7 years; previously by general practitioner for 30 years; all private offices, private consultation room, business office, x-ray and three treatment rooms, plus large reception room. Excellent corner location. BR. 9-9401; after 6 p. m., BR. 9-2349.

PHYSICIAN WANTED To take over on rental basis a fully equipped recently deceased doctor's office in southwest Ohio community of 100,000. Records available. $125.00 per month, complete. **Call Cincinnati PL 1-4392.**

COLORED OBSTETRICIAN or PEDIATRICIAN, Cin'ti, Ohio: Excellent opportunity in new medical center; No capital investment required; owner will remodel to suit; wood paneled waiting room, private office, receptionist area and examining rooms. Building also houses Medical Doctor, Medical Laboratory and Dentist Suites. June graduates invited to investigate. Wm. G. Menke, 2532 Indian Mound Ave., Cin'ti 12, Ohio.

PHYSICIAN to take over well-established practice in prosperous west-central Ohio community; modern office, equipment, furniture, instruments, files, etc., ready for physician to move in and start practice; GP needed in community; local hospital now expanding; rent, lease or buy on terms. Box 262, c/o Ohio State Medical Journal.

PICKER X-RAY - FLUOROSCOPE: Tilt table; 100 MA - 100 KV with all accessories. Michael Truman, M. D., 1070 Millville Ave., Hamilton, Ohio; 895-4541 or 895-9498.

FOR RENT: Office suite in new building, air-conditioned, on ground floor, ample parking. Located near hospital in community needing additional doctors. Reply Box 253, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER Interested in Psychiatry. Several staff openings exist at new NP Hospital activated last September in Greater Cleveland area. Expanding to 1,000 beds. Excellent working conditions and Federal service fringe benefits including cost of moving. Informal training provided by Board certified Psychiatrists. Salary dependent upon qualifications. Write: Director, VA Hospital, Brecksville 41, Ohio.

EXCELLENT OPPORTUNITY For someone interested in any practice in South-West Cleveland suburban; house-office with equipment, garage and parking place in front. Available from June 1st 1962. Box 265, c/o Ohio State Medical Journal.

WANTED: Full time physician for large Railroad; to be located in Cincinnati. Graduate of Class A Medical School, 8 hours, 5 day week, vacation and fringe benefits. Box 267, c/o Ohio State Medical Journal.

PEDIATRICIAN, BOARD eligible, wanted in a two board member partnership of whom one will retire in July. New associate to have immediate partnership status if desired and assured percentage of earnings of a large practice. Location in nearby suburb of Cleveland in a prosperous growing residential area close to teaching institutions. Box 268, c/o Ohio State Medical Journal.

FOR SALE or RENT: Excellent $50,000 gross General Practice; located Columbus Grove, Ohio; ten year old office-house combination; equipment; records; 20 car black-topped parking area; one acre landscaped yard; 6 acre fenced field; beautiful stable; riding ring. Good schools; 5 churches; excellent community; 2 good open staff hospitals in Lima, O., 12 miles southeast. Will introduce. R. B. Lucas, M. D., R. #3, Columbus Grove, Ohio.

FOR RENT IN MARION, Ohio, a Clinic Building, in a good location that will accommodate 4 or more Physicians. The floor arrangement consists in the right wing of a large waiting room, a general office for Secretary-Bookkeeper, an ENT room equipped with an electric Retter outfit and accessories, an X-Ray and dark room, and a Clinical Laboratory. The left wing has a large room for EKG, BMR and an electric automatic apparatus which records the precise systolic and diastolic blood pressure. There are two separate rooms for GYN, proctologic and general examinations. The last room on the left is used for minor dressings, minor accident cases, and parenteral medication. There is a rest room for men in the right wing and one for women in the left. There is a drug room in the rear between the right and left wings and a small waiting room for the X-Ray Department and drug room. There is another small waiting room adjacent to the laboratory and still another small waiting room for minor dressings. The building is heated by a hot water system. The working equipment consists of chairs, desks, and filing equipment. There is GYN, Orthopedic, and general surgery equipment. The owner has a good sized parking lot which can be made available for Clinic patients. Box 270, Ohio State Medical Journal.

WANTED: MEDICAL DIRECTOR and SUPERINTENDENT for modern (built in 1950) 80 bed County Tuberculosis Hospital. Serving a county of 100,000 population and surrounding counties on contract basis. Private practice permitted. Apply: Mr. H. D. Gregg, Chairman, Board of Trustees, Richland Hospital, Mansfield, Ohio.

GENERAL PRACTITIONER: In Sunbury, Ohio, rapidly growing area 20 minutes from Columbus; good schools, churches, shopping and recreational areas nearby; reasonable taxes and utilities; office in new Sunbury Medical Bldg. available; hot water, heat, air conditioned. Philip Holmes, D. D. S., 1961 graduate of OSU in one side of bldg. Phone Dr. Holmes — Worth. 5-5026, or Ted L. Forman, Worth. 5-5876.

APPROX. 1500 sq. ft. available for General Practitioner or Internist; long lease available at very nominal rental; ample blacktop parking; north area of Columbus; busily traveled streets; next to modern drug store. Box 271, c/o Ohio State Medical Journal.

FOR SALE: Licensed 49-bed hospital, Florida State Board approved in desirable location in Miami. Contact Mr. D. Collins, Administrator, 1750 N. E. 167th St., North Miami Beach, Fla.

FOR RENT: Very desirable suite of Medical Offices at nominal rental in Medical Bldg., 625 Cleveland Ave., Canton, Ohio. Excellent parking facilities. To inspect, and for details, contact Mr. James Seccombe, Canton, Ohio; Telephone 452-0691 or 456-0275.

ATTENTION, Residents of Ophthalmology or Otolaryngology: Having been forced to retire because of permanent disability, I am offering for sale: Eye Instruments, Ear, Nose and Throat Instruments, and Rhinoplastic Instruments. Most of the instruments are of stainless or rustless steel and in excellent condition. Box 273, c/o Ohio State Medical Journal.

GENERAL PRACTICE available July 1. Active, established 7 yrs.; town of 12,000, near Akron & Cleveland, with open staff hospital. Asking less than replacement of equipment. No cash necessary. Leaving state to specialize. Box 272, c/o Ohio State Medical Journal.

PRACTICE ON THE SHORES OF LAKE ERIE Near Islands. Opportunity for young American-trained man with family who loves outdoors. Buy this equipment and General Practice (30% Anesthesia). Low rent. Collections excellent in this modestly thriving practice established 8½ years. Town of 6700 between Sandusky and Toledo, draws from densely populated rural and shoreline area of 15,000, growing all the time. Office personnel can remain. Hospital 3 minutes away. Available in June or July. Box 258, c/o Ohio State Medical Journal.

PATHOLOGIST: Board eligible or certified for well established specialty group leading to full partnership. Excellent financial arrangements. Group is located in fully accredited hospital with completely new well-equipped, well-staffed laboratory. Furnish complete autobiography in initial reply. Write Box 274, c/o Ohio State Medical Journal.

*(More Classified Ads on Facing Page)*

## Medical Educators Honored By Ohio State Alumni

Three medical educators were honored with special awards at the annual alumni reunion of the Ohio State University College of Medicine at the Ohio Union April 14.

Dr. Russell G. Means of Columbus, emeritus associate professor of otolaryngology, was awarded a special honor for his leadership in the late 1930's and early 1940's in bringing about the erection of the present Ohio State Health Center. His leadership received special citation, and a bronze plaque in his honor was presented by former Senator John W. Bricker, chairman of the University Board of Trustees, in behalf of the alumni of the College of Medicine. The plaque is to be hung in Hamilton Hall, seat of the college. Presentations of other awards were made by Dr. C. Joseph DeLor, professor of medicine, at Ohio State.

Dr. Means' contributions as physician, educator and civic leader also were cited in the honor accorded him.

Dr. Ray W. Gifford, Jr., a 1947 graduate, received the Alumni Achievement Award, granted to graduates of the College of Medicine for "outstanding professional attainment and distinguished service to mankind" in medicine. Dr. Gifford is associated with the Cleveland Clinic's Department of Hypertension and Renal Diseases and has engaged in research in this field.

The Award of Merit, granted for the same achievements to associates graduated from other schools, was awarded to Dr. John B. Brown, chairman of the Department of Physiological Chemistry and Pharmacology. Dr. Brown has been director of the Institute of Nutrition and Food Technology since 1950. He has been a member of the Ohio State faculty since 1924, and has been active in research in fats and oils, fatty acids, lipids, and related areas.

Seventeen members of the Class of 1912 received Certificates of Achievement, honoring their first 50 years in medicine. (See picture on Front Cover.)

## Classified Advertisements (Contd.)


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ATTN. JUNE GRADUATES: Three offices for lease in Fairborn. New building, ground floor, paved parking lot, front & rear entrances. Located in community needing additional doctors. Box 263, c/o Ohio State Medical Journal.

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AVAILABLE: Custom built office suite, Maple Panelled, 300 m-a XRay unit in special lead walled area in Eastern area of Cincinnati, Ohio. Central air-conditioning and heat, 25-30 space auto facilities at rear door. Box 275, c/o Ohio State Medical Journal.

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*REFERENCES: (1) Roseman, E.: Neurology* **11**:*912, 1961. (2) Bray, P. F.: Pediatrics* **23**:*151, 1959. (3) Chao, D. H.; Druckman, R., & Kellawoy, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.: M. Clin. North America* **12**:*317, 1958. (5) Livingston, S.: The Diagnosis and Treotment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (6) Ibid.: Postgrod. Med.* **20**:*584, 1956. (7) Merritt, H. H.: Brit. M. J.* **1**:*666, 1958. (8) Carter, C. H.: Arch. Neurol. & Psychiat.* **79**:*136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (10) Goodman, L. S., & Gilman, A.: The Phormacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.*

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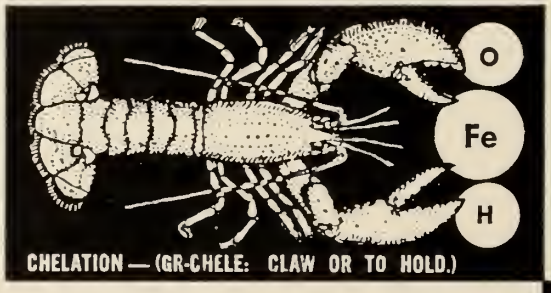
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| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
| Toledo | Toledo Health Department<br>635 N. Erie St. | CH 4-1961—(Day)<br>EV 5-4661—(Night) |
| Youngstown | Emergency Room Dept.<br>St. Elizabeth Hospital<br>1044 Belmont Street | RI 6-7231, Ext. 220 |


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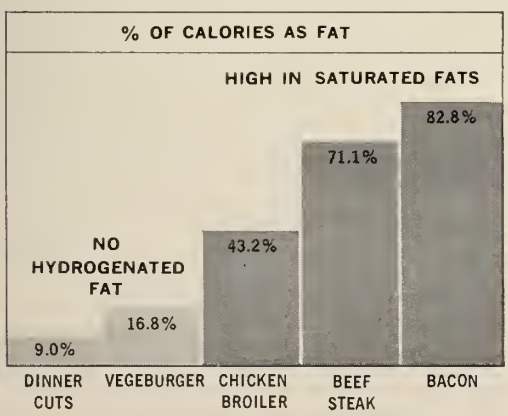
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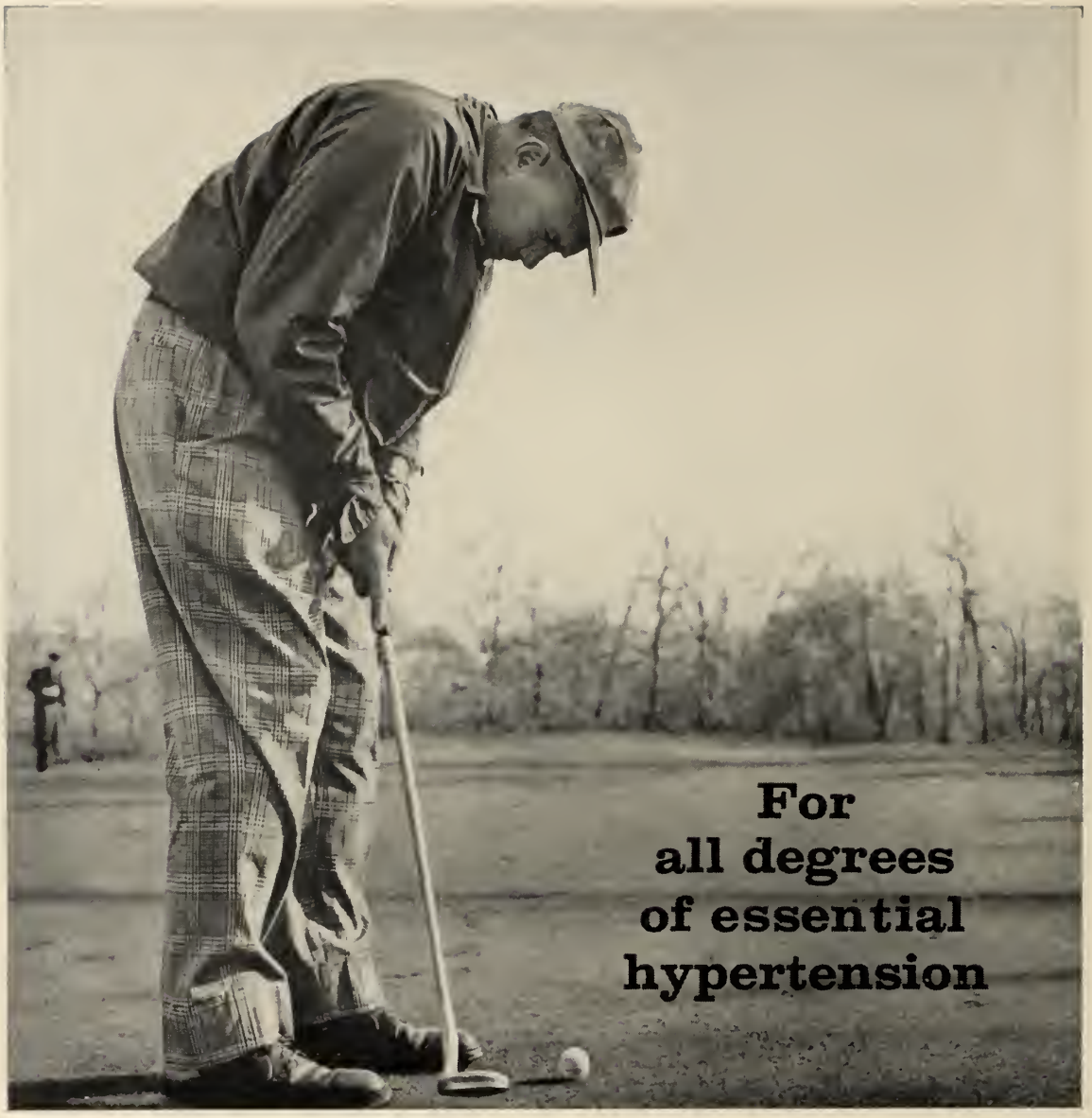

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| French Style Dressing | 1 tbsp. | 10½ | 60 |
| Brown Gravy | 1 tbsp. | 7 | 21 |

| | Quantity | Figure Control Calories | "Regular" Food Calories |
|---|---|---|---|
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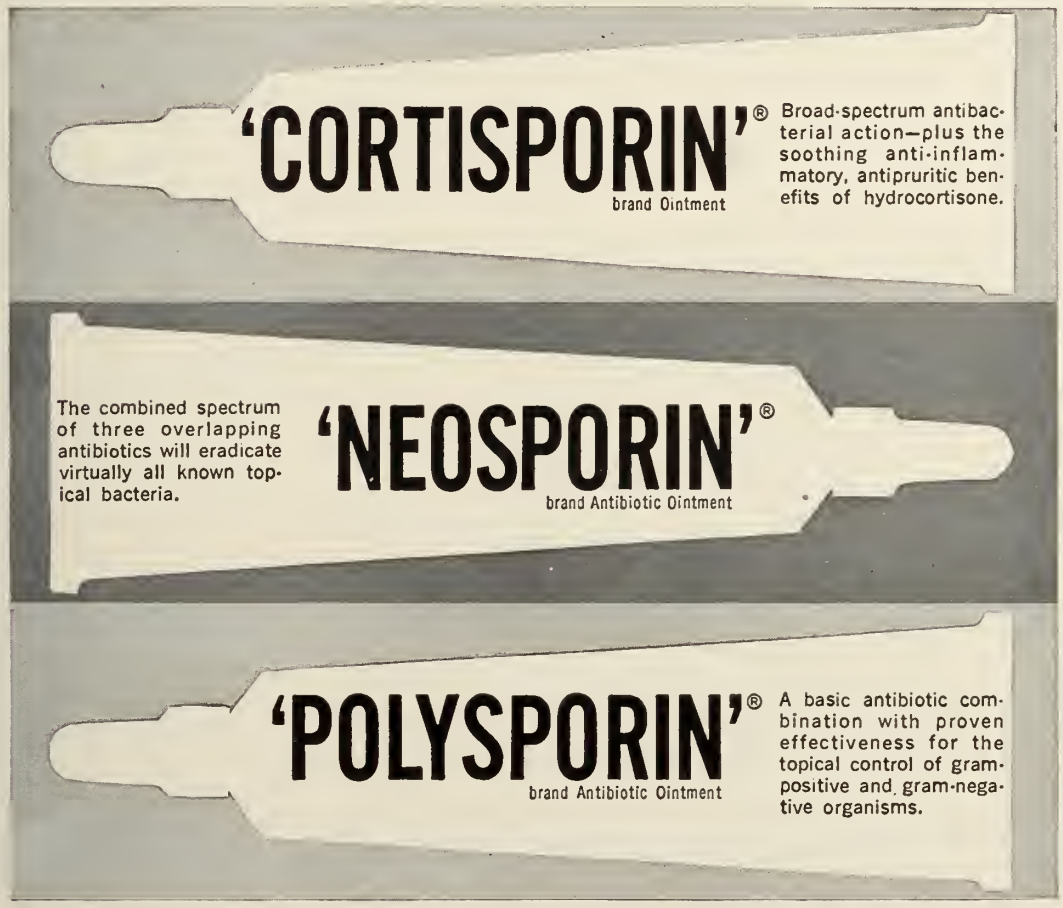
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(1) Bernstein, A. & Simon, F. "The treatment of Obesity in patients with Cardiovascular Diseases" Presented at Am. Coll. of Angiology meeting; June 12, 1960.

(2) Plotz, M.: Modern Management of Obesity, J.A.M.A. 170:1513-1515 (July 25) 1959.

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*Gamble, C. J.: Am. Pract. & Digest Treat. *11*:852 (Oct.) 1960. See also Berberian, D. A., and Slighter, R. G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Olson, H. J.; Wolf, L.; Behne, D.; Ungerleider, J., and Tyler, E. T.: California Med. *94*:292 (May) 1961; Kaufman, S.A.: Obst. & Gynec. *15*:401 (Mar.) 1960; Warner, M.P.:J.Am. M. Women's A. *14*:412 (May) 1959.

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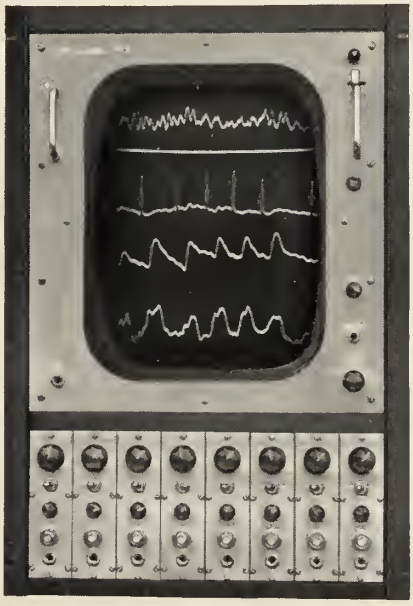


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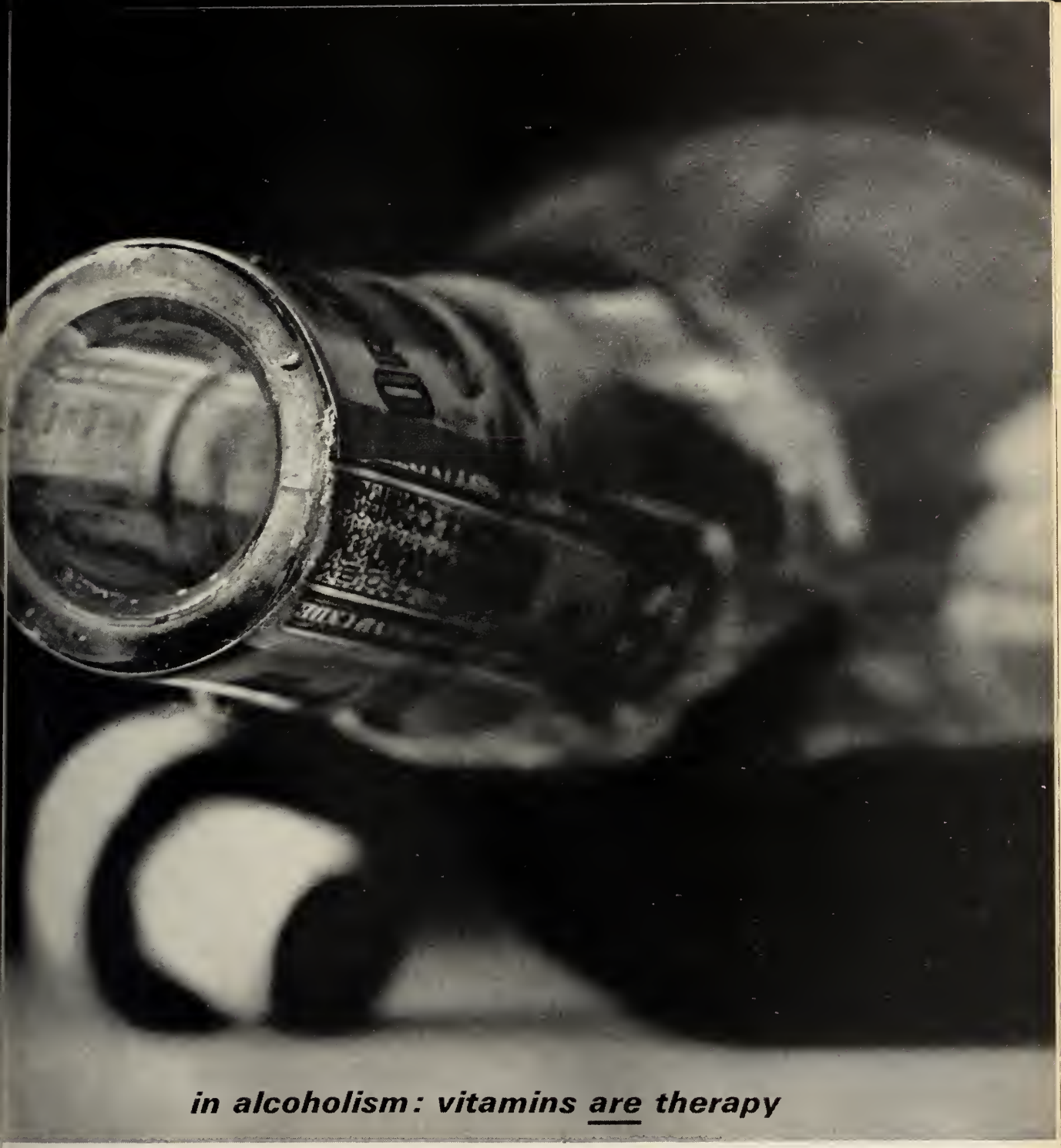


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The Historian's Notebook

# History of the Lakeside Unit Of World War I

HARRY D. PIERCY, M.D.*

## Part II

*(Continued from May Issue)*

THE UNIT reunited at Southampton and crossed the channel on the night of May 24 on the British Hospital Ship, *Western Australia.* Sailing up the Seine toward Rouen on the 25th the boat was greeted at every village and port by the French people, cheering and shouting "Vive les Americans." Docking at Rouen in the evening of the same day the Unit was enthusiastically received by the English and French officials as the first American troops to land in France. Disembarking, they formed ranks, and preceded by the drum and bugle corps and the American flag, the officers and men, equipped with side arms and machettes, followed by the nurses, marched in an impressive file, between lines of cheering Frenchmen out to the Barrier. Buses were waiting there to convey the entire command out to General Hospital No. 9 B. E. F., a distance of about five miles.

### Additional Personnel

In September, 1917 additional personnel of officers, nurses and enlisted men arrived. There were nine officers, among whom I was one, about 20 nurses and 30 enlisted men. Our group came on the *S. S. Adriatic.* There were two companies of New York State infantry and artillery that went over with us; it was said that about 500,000 American troops had arrived in the preceeding three months. Our group was known as Reserve Personnel and had been standing by for orders since the Unit left in May. We were warmly welcomed but with less ceremony than that which greeted the first unit of the U. S. Army.

Our nurses with few exceptions were graduates of Lakeside Hospital. They were under the supervision of Miss Grace Allison, head of the School of Nursing at Lakeside Hospital. Miss Allison continued on her overseas duty until the late summer of 1918, when she was relieved to resume her former position in Cleveland. Miss Elizabeth M. Folckemer, on duty in our hospital, next was appointed in charge of nurses, a position which she retained until the nurses were returned home and demobilized April 10, 1919, at the Albert Hotel in New York City.

### Commanding Officers

Colonel Gilchrist continued in command of the unit until December 4, 1917, when he was transfered to the A. E. F. to the Division of Gas Warfare.

Major W. E. Lower was ordered to succeed Col. Gilchrist and he continued in this post until May 10, 1918, when he was relieved of duty to return to the United States.

Major Walter C. Hill assumed command on May 10 and was relieved on June 6. Captain Allen Graham was next in command from June 6 until Colonel Frank E. Bunts arrived on August 27. Col. Bunts continued in this office until the Unit was brought home and demobilized at Camp Sherman, Chillicothe, Ohio, in April 1919.

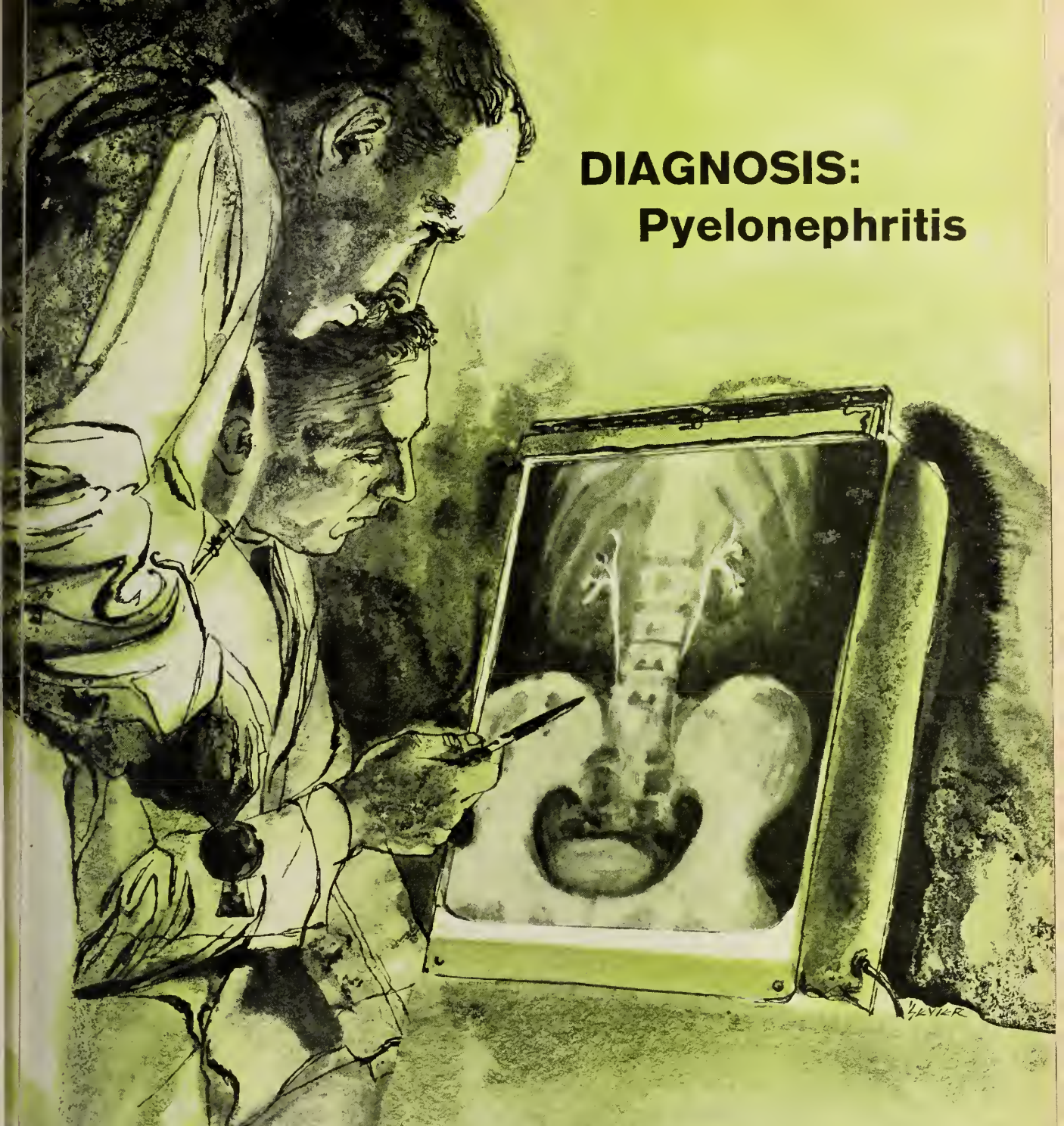
Colonel Bunts was a popular and much respected Commanding Officer. He had graduated from the Naval Academy on June 10, 1881, and retired from the Navy upon completion of the required two year cruise, in this instance to the oriental stations, Hong Kong and Japan. He was tall and slender and he had a distinct soldierly bearing. He made friends readily with both the British and the French, laymen as well as the military. His presence contributed greatly to the social life in camp and town.

### Major George W. Crile

Major George W. Crile was carried on our organization as General Clinical Director, however he was loosely attached to our Unit, for his services and his advice were sought by the British and the French in the forward areas and he travelled about with a chauffeur, in a Maxwell car from Dunkirk east to the French lines, many times with the barrage sailing overhead and too close to airplane bombs for comfort. His energy seemed inexhaustible. He soon had research problems going in the Casualty Clearing Station (C.C.S.) as well as at No. 9 Hospital. These problems were concerned with the

*Dr. Piercy, Cleveland, is a member of the courtesy staffs of University Hospitals, and St. Luke's Hospital, Cleveland, Ohio.

Submitted June 23, 1961.




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treatment of shell shock, exhaustion, the management of fractures and infection, especially gas gangrene; trench fever, scabies; mustard gas and phosgene poisoning.

An Interallied Surgical Congress was held monthly by the Red Cross, usually in Paris, and here these important problems were discussed and communicated to representatives of the French and British Hospitals. There were no antibiotics; wounds and infections were treated with Carrel - Dakin Solution, eusol, B. I. P. (bismuth iodoform paraffin), salt packs, incision and drainage, and extensive lavage. These measures gave results that were less than satisfactory, judged by our present methods of treatment.

### The Hospital Base

General Hospital No. 9 B. E. F. was centrally located in a group of large British hospitals. This base had been well organized, carefuly planned, and substantially constructed. No. 9 contained about 20 to 30 wooden "huts." The floors were elevated from 12 to 20 inches from the ground and above them were the tight wooden sides with ample windows. Over all was a well shingled or composition roof. The medical and surgical huts each contained about 30 beds. There were two small rooms at one end for the seriously ill, and the nurses' office and preparation rooms were at the other end. Coal-burning stoves heated the wards, and coal oil Princess stoves stood on a bench in the nurses' quarters and supplied heat for sterilizing and for brewing a "spot of tea."

The Administration Building, recreation hall, the mess halls and kitchens were in substantial wooden huts, and officers, nurses and enlisted men were all comfortably housed. Officers were two to a room. There was a small stove with a teakettle on top and the Irish batman would secure, by means known only to himself, sufficient coal to warm the room on the damp chilly mornings. The fire started, he would shine the shoes, leggings and the Sam Brown belts and then if we were oversleeping, he would gently awaken us.

### Surgery

The surgery was done in a large building that had a level cement floor. This accommodated up to six operating tables. In an alcove off to one side was the x-ray department under the management of Major Walter C. Hill, and behind a partition was the sterilizing room for instruments and dressings. This was a busy surgical theatre. Operations ran 10 to 30 and more a day, depending upon the nature of the wounds and the supply of anesthetic which sometimes ran low. During the German push, starting on March 21, 1918, advancing on Amiens, wounded patients poured into the hospital in numbers never seen before. Seven hundred and forty patients were received and 104 operations were done on that date.

On March 24th, 760 patients received, hospitals and tents full and patients on stretchers strewn over the lawn; operating room working 24 hours each day and some surgeons working 16 to 24 hours. Easter Sunday, March 31, was the record day for the hospital, over a thousand patients admitted and operations running up to 100 each 24 hours. This drive continued for a couple of weeks and then tapered off, and hours of lost sleep were recovered and flagging energies were revived.[2]

During this period the hospital was sandbagged and five foot deep trenches were dug in the nearby lawns; these were for the walking sick and injured in case the hospital was bombed. During the spring of 1918 "Fritz" bombed the docks and on one occasion dropped a magnesium flair, lighting up the entire base. Many anti-aircraft defenses were installed and on his subsequent visits the air was full of schrapnel and some nose caps fell in our grounds. No one was injured. These small air raids were trifling disturbances to our patients who had been on the front and I can't recall any of them taking to the trenches. They were, of course, terrifying to the shell-shocked patients.

There were also a number of 14 by 24 foot wall tents equipped with beds and bedside tables. These were occupied by the lightly wounded and the walking sick and they served well for crisis expansion when the casualties were greatly increased and our surgical and medical huts overflowed.

### Chaplains and Church Services

There was a church tent where services were held for the Church of England and the English Wesleyan faiths. The Catholic services were held in a chapel in a nearby camp. In October 1918, the enlisted men under the direction of the English Wesleyan Chaplain, Padre Boice, erected a log church and Thanksgiving services were held in this appropriately decorated rustic chapel.

The Chaplains of the various faiths led busy lives, bringing comfort and cheering words to the sick and wounded, writing letters to relatives and giving a helping hand wherever help was needed. They were splendid men; valuable additions to our command, promoting harmony and friendliness between the sick and those who cared for them. They were interested as well in the recreational activities in the camp and joined the tea tables of the men, officers and nurses, and were always ready to be a fourth in a table of bridge.

*(To Be Continued in July Issue)*

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**Archives of Films in Medicine.** — A transfer of the medical motion picture archives to the Audio-visual Facility of the USPHS Communicable Disease Center in Atlanta became effective January 1. The transfer of function from the Library in Washington, D. C., involved the entire reference and historical collection of medical films and associated files.




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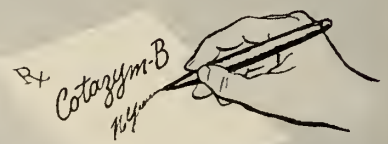
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OSMJ Scientific Section

VOL. 58 JUNE, 1962 NO. 6

# Childhood Plumbism

## Doctor, Would You Think of Lead Poisoning?

OTTO P. PREUSS, M. D.

LEAD POISONING in children is not a new disease but only over the past 10 years has the disease received its due attention. Common to all reports is the emphasis on two essential facts: first, the disease occurs much more frequently than generally realized; and second, failure to appreciate this frequency is responsible for many missed cases.

Especially during the early stage, symptoms of lead poisoning are nonspecific. Pallor, anorexia, abdominal cramps, nausea, vomiting and headaches, even if occurring repeatedly, are all symptoms easily ascribed to many other and less remote causes. Only the exceptionally interested or otherwise alerted physician, if confronted with a toddler showing the above symptoms, would consider the possibility of chronic lead absorption right away.

Even the advanced, encephalitic stage appears to give only infrequent reason for suspecting lead as the responsible agent. This is strikingly demonstrated by mortality figures on accidental poisoning compiled by the Division of Vital Statistics of the Ohio Department of Health. Over the past 10 years, 55 deaths from lead poisoning have been reported in children of ages 1 to 4 years, the age group mainly affected by this problem. This is an impressive figure, but one will be even more surprised to learn that all but two of these cases originated from Cuyahoga and Hamilton Counties.

There is obviously little reason to believe that in other counties with large metropolitan areas not a single fatal case of lead poisoning should have occurred. The only answer to such seemingly unequal distribution then must be that in these areas cases of lead encephalitis (the late stage of lead poisoning and the only form leading to death) are not recognized as such but presumably are considered to be of viral origin. On the other hand, there can be no doubt as to the correctness of diagnosis on the 53 cases reported from Cleveland and Cincinnati. Both areas had facilities readily available for the analysis of lead levels in blood and urine, an important prerequisite for confirming any diagnosis of lead poisoning. The readiness of the laboratories to cooperate with the physicians in these areas obviously played a role in stimulating and maintaining interest in childhood plumbism.

This shows clearly how important it is to maintain a high index of suspicion, if oversight of chronic lead absorption with its possible serious consequences is to be avoided. The prognosis of advanced lead intoxication in children is grave. If the habit of ingesting paint or other materials containing lead remains

Submitted May 12, 1961.

### *The Author*

● Dr. Preuss, Cleveland, former occupational health physician, Division of Industrial Hygiene, Ohio Department of Health, Columbus, is now a member of the Department of Industrial Medicine of the Euclid Clinic Foundation in Cleveland.

unchecked, lead encephalitis is likely to occur. The mortality rate of this disease is approximately 20 per cent. Furthermore, a substantial number of the surviving children show signs of permanent brain damage ranging from mild behavior disturbances to visual impairment and severe mental retardation. Quite in contrast to the early stages of lead intoxication, which can be controlled by eliminating the lead source and administration of chelating agents, there is little that will significantly influence the course of the encephalitic stage. The emphasis, then, must shift to preventive measures as the only method for averting toxic effects on the central nervous system. Here, strict supervision of the child's habits and removal of the source for lead ingestion from the child's environment are the most important steps. However, this necessitates the early diagnosis of lead intoxication.

It shall not be the purpose of this article to discuss differential diagnosis and treatment of childhood plumbism at great length, since excellent papers dealing with both topics and prepared by authors with much clinical experience on the subject are available. However, a brief rundown on the highlights of etiology, incidence, symptomatology, and therapeutic principles seems to be in order for the benefit of those physicians who have had very little contact with this form of lead poisoning.

## Etiology

Layers of paint on older homes represent the most important offending agent. Such paint frequently contained 10 to 15 per cent lead pigments and was used for interior as well as exterior decorating. Paint on walls, plaster, wallpaper, window sills, door frames, or bannisters will provide the most common source, especially in those homes which were formerly kept in excellent repair with many coats of paint. Former one-family homes now subdivided into multiple family dwellings as well as formerly better apartment houses now turned into slums fall definitely into this category. Many of these houses are now in a poor state of repair, and the paint is allowed to crack and to peel with flakes falling down to the floor. Any curious toddler, of course, may pick up and sample such chips. However, it is the child with need for attention, with nutritional deficiencies, and with behavior problems, who will develop the habit of ingesting such flakes or chewing on a window sill regularly and who will gradually absorb large amounts of lead. A history of pica appears to be the most common feature among children seen with signs of lead intoxication.

One single paint flake one-third inch in diameter and weighing 500 mg. may contain 5 to 10 times the amount of lead which can be ingested safely on a continuous basis. If the habit of ingestion persists, signs of intoxication may become manifest after approximately three months.

Today's indoor paints contain very little or no lead. Their newly developed synthetic vehicles make it possible to utilize other pigments than the fairly expensive lead carbonates or lead chromates. However, outdoor paint may still contain a high percentage of lead because of its excellent weather resistance. Thus, flaking outdoor paint may also present a definite hazard if found in a youngster's favored playing corner. Paint on toys or children's furniture, as long as they have not been repainted with an outdoor paint, presents a lesser danger. In 1955, the American Standards Association recommended to the American Association of Toy Manufacturers to use not more than 1 per cent lead pigment in paint applied to toys. This seems generally to be followed.

## Incidence

Although correct incidence figures are hard to establish, the mortality statistics previously mentioned may give us some idea as to the order of magnitude of this problem. The reported 55 deaths in 10 years came from two metropolitan areas with a combined population of approximately two million. In applying the accepted mortality rate for lead encephalitis of about 20 per cent, one will, by means of extrapolation, arrive at a total of approximately 250 cases of encephalitis. These, of course, had to come from a much larger number of children with milder forms of lead intoxication or subclinical signs of lead absorption.

It should be stressed that this calculation has been extremely conservative and that any such estimate should be received with caution. It should also be pointed out that the reported deaths were diagnosed on account of a high index of suspicion, which naturally resulted in a larger number of cases diagnosed early enough to prevent the development of encephalitis.

Still unexplained is the uniform observation that almost all cases occur during the warm summer months. Increased lead absorption caused by the more intensive ultra-violet radiation and greater toxic effects from lead on account of dehydration have been suspected, but no proof of these theories has been introduced so far.

## Diagnosis

Age (1 to 4 years), a history of pica, and characteristics of the child's environment will provide valuable clues. The initial symptoms are unfortunately quite nonspecific. Anorexia, persistent unexplained anemia, recurrent colic, constipation, frequent vomiting, and headaches may all be signs of the early stage, which involves chronic irritation of the intestinal tract and effects on the hemopoietic system. As the central nervous system gradually becomes affected, one will see behavioral changes, irritability, restlessness, and loss of recently acquired habits such as toilet training. Finally, with increasing inflammatory response of the brain tissue, there will be signs and symptoms of rising spinal fluid pressure with severe persistent

headaches, bouts of spontaneous vomiting, severe restlessness, and eventually stupor, sleepiness, and coma.

The spinal puncture will show considerable increase in pressure, few cells, and elevated protein values. X-ray evidence of radiopaque material in the abdomen and increased density of the epiphyseal lines of the long bones will provide further important clues, but these are not specific for lead. An increased stipple cell count or an elevated urine-coproporphyrin concentration may be helpful in establishing a differential diagnostic pattern, but may be abnormal in other conditions, too.

The most valuable and indispensable procedure for confirming the clinical diagnosis is determination of lead concentration in blood and urine. Urine lead concentrations, however, may be subject to wide daily fluctuation. They may indicate that excessive amounts of lead were absorbed recently but provide little information as to extent and duration of such absorption. The normal range of urinary lead is between 0.03 and 0.06 mg./liter. Excessive lead absorption can be suspected with values of 0.08 mg./liter and higher. Blood lead levels on the other hand are relatively constant and will increase much more slowly and only with prolonged lead absorption. In a child the blood lead concentration should not exceed 0.05 mg./100 Gm. blood. If values higher than 0.06 mg./100 Gm. are obtained, one can assume that abnormal amounts of lead have been ingested for a longer period of time. Values exceeding 0.08 mg./100 Gm. should be considered a definite danger signal even in the absence of manifest clinical symptoms. The definite diagnosis of lead poisoning should, of course, always be based on clinical findings and never on laboratory findings alone But it is this group of children with blood levels higher than 0.08 mg. from which the cases with severe signs of intoxication will develop, sometimes within a few days or weeks after their blood has been examined. These children need to be removed from their source of lead intake immediately and, depending on the blood lead concentration, may require elimination of the absorbed lead from the soft tissues by active therapeutic means.

## Therapy

For children with mild symptoms and positive, but moderate, evidence of lead absorption, removal from the lead source will be sufficient. If the blood level is higher than 0.07 to 0.08 mg./100 Gm. blood, indicating more intensive and prolonged lead absorption, the child should be hospitalized and at least one course of Edathamil Calcium Disodium is recommended. This chelating agent has a high affinity for lead and will convert the toxic metallic ion into the harmless non-ionic stage, which will be eliminated from the soft tissues via blood stream and kidneys. Possible side effects from this drug require that it be used discriminately and with the necessary precautions quoted in the literature. If severe symptoms are present, they will have to be treated accordingly. In all instances, it will be of extreme importance to prevent further lead ingestion by ascertaining that all potential lead sources will be eliminated from the child's environment. This can be accomplished through the cooperation of the local health department with public health nurses assuming responsibility for the education of the child's parents.

## Summary

Lead poisoning in children occurs much more frequently than generally realized. Distribution of mortality figures suggests strongly that lead as the etiological agent has not been recognized in most parts of the State. Essentials of etiology, incidence, diagnosis, treatment and prevention of childhood plumbism are presented.

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LEAD POISONING IN DEMOLITION WORK. — This is a report of the occurrence of at least seven instances of lead poisoning developed among workers exposed to high concentrations of lead while cutting steel girders coated with several layers of lead paint. The work involved was the demolition of a rural bridge. All work was in the open and manifestly the natural ventilation was good. The significance of this brief report is that many occupational diseases, including lead poisoning, may arise wholly apart from the factory type of industry. — W. W. McBride, M. D., and E. G. Proctor, M. S. P. H., Harrisburg, Pa.: *Industrial Medicine and Surgery*, 31:31-32, January 1962.

# Management of Ureteral Colic Due To Calculus Disease

J. KENT TRINKLE, M.D., and CHESTER C. WINTER, M.D.

THE PHYSICIAN is seldom confronted by a more distressed patient than one with ureteral colic. The pain is severe, a fact which may cause both patient and physician to overrate the gravity of the situation. This paper is a discussion of the diagnosis and treatment of ureteral colic due to a calculus as practiced at the University Hospital. Three cases are presented and discussed.

### Incidence and Distribution

Reports from various hospitals indicate that urinary calculi are the cause of from 2 to 12 of every 1000 hospital admissions.[1,2,3] The incidence is low in Negroes[2,4] compared with Caucasians and Orientals. Urinary calculi are rare in children except in eastern Europe and Asia where poor nutrition is thought to be an etiologic factor.[6] Urinary calculi in the United States are more frequent in the southeastern and southwestern areas.[3] Various factors have been implicated in this geographical distribution including diet, dehydration and excessive actinic vitamin D production.[4,5]

### Symptoms and Diagnosis

Pain and microscopic hematuria are virtually diagnostic of ureteral colic due to a calculus. The distribution of pain depends on the point where the calculus obstructs the ureter. The ureter has three constricted areas where stones usually lodge: the ureteropelvic junction, the junction of the lower and middle thirds of the ureter where it crosses the pelvic brim and iliac vessels, and the ureterovesical junction. A stone lodged at the ureteropelvic junction produces flank pain, lodged at the pelvic brim it is referred to the lower abdomen, and lodged at the ureterovesical junction the pain radiates to the genitalia and medial side of the thigh. This distribution of pain in relation to the position of the stone is not constant, however.

Hematuria is seldom grossly visible,[3] but red blood cells are noted on microscopic examination of the urinary sediment. Occasionally the urine has a "smoky" appearance. A common fallacy is to catheterize a possible "stone patient" to obtain a urine specimen. This practice is to be condemned. The trauma of the catheterization alone can cause microscopic hematuria, thus obscuring the diagnosis. Also catheterization may introduce bacteria into a previously sterile urinary tract. A clean voided, three glass urine speciman is preferable.

The patient also may have mild tenderness over the area of pain. Reflex ileus may occur as well as nausea and vomiting. If the stone is lodged at the ureterovesical junction there may be urgency and frequency due to bladder irritation. The patient may have a few white blood cells and albumin in his urine, leukocytosis and low-grade fever without urinary infection. However a history of chills, marked elevation of temperature, or bacteria demonstrable in a strained smear of the urinary sediment is indicative of a superimposed urinary tract infection and is an indication for appropriate drug therapy.

### Roentgenological Examination

All patients with a possible ureteral calculus should have a plain roentgenogram of the abdomen. The majority of urinary calculi are radiopaque, containing calcium in either pure or mixed forms. Only uric acid and the rare xanthine calculi are radiolucent although cystine stones may be only faintly visible. Tumor, blood clot and inspissated pus are also radiolucent and may cause obstructive symptoms. A number of abdominal calcifications may be confused with

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ureteral stone. These include: phleboliths, calcified costal cartilages, arteriosclerotic plaques, calcified lymph nodes, pancreatic calculi, gallstones, fecoliths, enteric coated tablets, retained barium and calcified tumors. In addition to noting the presence or absence of calcified lesions, the physician should note the character of the bones with regard to osteoporosis, metastatic lesions, cystic degeneration and arthritic changes, all of which may indicate abnormal calcium and phosphorus metabolism. Lumbar scoliosis, due to muscle spasm, with concavity toward the side of the pain, may be present.

The next procedure is to obtain an intravenous pyelogram. A high degree of ureteral obstruction by a calculus will cause delayed visualization of the renal pelvis and ureter on the obstructed side and is frequently preceded by generalized opacity of the kidney ("nephrogram") on the affected side. If slow visualization occurs, delayed films from 1 to 24 hours should be made until the contrast medium is seen. Occasionally several deep breaths, the Sedlezky maneuver, will aid in visualization of the ureter. When the ureter fills with contrast medium a radiolucent halo is frequently seen surrounding the stone. If the stone is in the lower portion of the ureter, the entire length of the ureter may fill with contrast medium. This is an event which rarely occurs without obstruction. Finally, to be certain that the calcification lies within the ureter and is not merely superimposed on it, an oblique film should be made. If a calcification is in line with the ureter in two views, it may be considered to lie within its lumen until proven otherwise. Before considering surgical intervention ureteral catheterization with anterior and oblique films should be carried out.

It should be remembered that other things besides a calculus can obstruct the ureter and cause colic, e. g. stricture; enlarged lymph nodes; retroperitoneal tumor or abscess; bladder, kidney, renal pelvis and ureteral tumors and blood clots.

## Treatment

The objectives of treatment of ureteral colic due to a calculus are fourfold: (1) relieve pain, (2) recover the stone, (3) prevent irreversible damage to the kidney and (4) prevent further stone formation. This paper is concerned with the first three.

The relief of ureteral colic usually requires large doses of narcotics. Antispasmotics such as atropine, belladonna, Pro-Banthine®, etc., are of occasional value. It is sometimes difficult to maintatin outpatients on oral narcotics and analgesics due to the nausea and vomiting which frequently accompanies colic.

Recovery of the stone may frequently be accomplished without surgical intervention. Smooth stones of 5 mm. or less in diameter will usually pass spontaneously. Stones 1 cm. or greater or highly irregular in shape usually do not pass spontaneously unless a chronically obstructed, dilated ureter is present. The patient should be instructed to drink large amounts of liquids and to strain his urine so that the stone may be recovered and its composition analyzed. Periodic roentgenograms for position and size of the calculus and *radioisotope renograms* for evaluation of renal function and drainage are ideal in the conservative management of ureteral stones. Frequently, edema and inflammation of the ureter may cause obstructive symptoms to persist for 48 to 72 hours after a stone has passed.

Irreversible renal damage can result from infection and/or hydronephrosis secondary to ureteral calculi. This is an important consideration in deciding upon surgical intervention. Other considerations are unrelenting pain and prolonged disability. Removal may be accomplished by surgical incision or through cystoscopic manipulation. Renal drainage may be accomplished by ureteral catheterization or, less often, nephrostomy. These procedures are more urgent if bilateral ureteral obstruction is present or if the function of the unobstructed kidney is inadequate and azotemia, hyperkalemia and acidosis cannot be controlled. Simple obstruction without infection, unilateral renal dysfunction or marked pain rarely warrant immediate surgical intervention without other indications. There are recent reports of three cases of complete ureteral obstruction by ligature for 33,



FIG. 1. *A smooth radiopaque calculus (arrow), 5 mm. in diameter, overlies the upper ureter. The renal pelvis shows a mild degree of hydronephrosis.*



FIG. 2. *An irregular, radiopaque calculus (arrow), 8 mm. in diameter, overlies the ureteropelvic junction.*

40 and 60 days. Complete function returned to the kidney in each of these cases after deligation.

## Case Reports

**Case 1.** A 27 year old white man entered the emergency room with the chief complaint of severe right flank pain of one hour duration. The pain did not radiate and was associated with no other symptoms. He had mild right flank tenderness and vital signs were normal. A complete blood count was normal but urinalysis showed 15 red blood cells per high power field. A plain roentgenogram of his abdomen revealed a calcification 5 mm. in diameter just below the right 12th rib (fig. 1). Intravenous pyelography showed normal visualization of the left kidney but delayed appearance of contrast material in the right kidney. The right kidney and ureter began visualizing in 30 minutes and the calcification was seen to overlie the ureter. An oblique film confirmed this impression. There were no bacteria or white blood cells demonstrable in his urinary smear and his blood urea nitrogen was normal.

In view of these findings it was elected to allow the patient to go home to await spontaneous passage of the stone. He was instructed to drink large amounts of liquids, strain his urine and to use codeine for relief of his pain as necessary. He was to be followed with weekly abdominal roentgenograms, urinalysis and radioisotope renograms. Three weeks after his initial attack of colic he passed the calculus spontaneously. The patient's radioisotope renogram which originally showed a mild degree of obstruction, returned to normal (fig. 3).

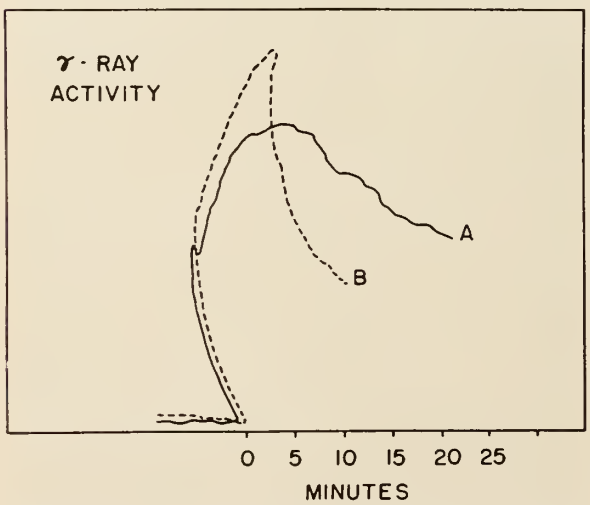



FIG. 3. *The renogram prior to passage of the ureteral calculus (a) shows mild delay in urinary drainage, i.e., a slow descent of the terminal tracing. The renogram after passage of the calculus (b) has returned to normal.*

**Case 2.** A 47 year old white man entered the hospital with the chief complaint of severe right flank pain of two hours' duration. He was nauseated. Physical examination was normal. The urine contained many red blood cells but no bacteria. A plain film of the abdomen revealed an irregular calcification 8 mm. in diameter, in the region of the right renal pelvis. Intravenous pyelography showed delayed filling of the right kidney and normal visualization of the left urinary tract. After six hours the oblique and anterior views showed the calculus to overlie the ureter at the ureteropelvic junction. After four days of marked pain and failure of the stone to move, the patient was taken to the operating room and the stone was removed through a pyelotomy.

**Case 3.** A 42 year old white man entered the hospital with the chief complaint of right flank pain, chills, and fever of approximately two weeks' duration. He had been treated during the time with sulfisoxazole and chloramphenicol without relief. Intravenous pyelography showed marked diminution of excretion of contrast material by the right kidney and visualization of the right urinary tract was delayed until two hours. There was a faintly opaque calculus, 7 mm. in diameter, overlying the right ureteropelvic junction on all views. It was felt that this patient had pyonephrosis due to an obstructing calculus. He was taken to surgery where the calculus was removed and approximately 100 cc of thick, purulent material was removed from a hydronephrotic right kidney. A nephrostomy tube was left in place. Subsequent tests showed diminished function of his right kidney which never returned to normal despite eradication of his infection.

## Summary

This paper is concerned with ureteral colic due to calculi. The incidence and geographical distribution of urinary calculi, the diagnosis and management of colic and the objectives of treatment have been discussed briefly. It has been emphasized that ureteral colic due to calculus is usually not a surgical emergency. Infection, renal failure, severe, prolonged pain and disability are usual indications for surgical intervention. Three typical cases of ureteral colic due to a urinary calculus have been presented which illustrate the principles advocated by the authors.

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# Genitourinary Care in Pelvic Surgery

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DURING recent years the use of the catheter in the female patient, whether for a single catheterization or continuous drainage, has become a focus for controversy. Some support its use, comparing it with an automobile in its relation to the transportation of an individual. Others assert that it is responsible for the occurrence of pyelonephritis and that its use may culminate in grave disorders.

In 1955, Beeson[1] stated that the possibility of upper urinary tract infection following cystitis had not been established. Three years later, he reported[2] that bladder infection not infrequently results from catheterization and that this may lead to pyelonephritis. Kass[3] found asymptomatic bacteriuria in 6 per cent of 337 women in the Medical Outpatient Department of the Boston City Hospital. He noted bacteriuria in 98 per cent of 100 patients in whom the indwelling catheter had been used for a four-day period.

The source of bacteriuria, according to Kirby, et al.[4] and Dutton and Ralston,[5] stems from a cross-infection of hospital personnel, multiplication of bacteria in the intestinal tract with access to the urinary tract, and contamination from mattresses and blankets to the skin and catheter. Kass and Schneiderman[6] referred to the constant entrance of microorganisms into the bladder during the utilization of an indwelling catheter. They suggested that the urethral exudate which forms around the catheter serves as a portal of entry for microorganisms. This exudate is not only an excellent culture medium but also links the rectal and vaginal flora of the perineum with the interior of the bladder.

Various investigators[7,8] have demonstrated the close anatomical relationship between the cervix uteri and bladder as regards common accessible routes for microorganisms. Not mentioning the vaginal and/or cervical condition, Kass[3] reported the presence of bacteriuria in 23 per cent of 52 women having cystocele. Foster[7] found that 32 per cent of 65 women with cervicitis had symptomatic urinary infection.

In attempting to combat the problem of patient discomfort and prevent urinary complications, a wide range of antimicrobial agents have been employed.[9]

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These preparations, administered systemically for their prophylactic action, have met with varying degrees of success.

After examining data based upon previous studies, the author feels that the prognosis in bladder infection and resultant morbidity following pelvic surgery depends to some degree upon a composite of factors: urethral and vaginal organisms and a foreign body reaction to the inlying catheter. The current study was undertaken in order to determine the value of an extensive therapeutic approach to urinary infection stemming from the use of the catheter in the female patient. Triclobisonium chloride vaginal suppositories and triclobisonium chloride lubricant jelly were used.

### Material and Method

One hundred and fifty hospitalized women requiring indwelling catheterization for a period of not less than 48 hours following pelvic surgery constituted the subjects of this study. They were divided into three groups of 50 patients each.

Upon admission to the hospital and before insertion of a catheter the urethral meatus of each patient was cleansed with Septisol®* and rinsed with 1:1000 aqueous Zephiran®** solution.** Cultures of the vagina, urethra and urine were then taken and the vagina was then cleansed with Septisol.

In Group I, following the initial procedure, 1 to 2 Gm. of Lubafax®† was introduced into the urethra. In Group II triclobisonium chloride†† lubricant was introduced into the urethra. In Group III, in addition to the urethral insertion of triclobisonium chloride lubricant, two triclobisonium chloride vaginal suppositories were inserted into the vagina. In each group, the tip of the catheter, after the first cultures

* Vestal Laboratories, St. Louis, Mo.
** Winthrop Laboratories, New York, N. Y.
† Burroughs Wellcome & Co. Inc., Tuckahoe, New York.
†† Roche Laboratories, Nutley, New Jersey.

were taken, was lubricated with the jelly initially used in the urethra. Vaginal, urethral and urine cultures were repeated 12 hours later in the operating room before insertion of the indwelling catheter and surgical procedure.

During the entire period of continuous urinary drainage, the catheter and urinary meatus were cleansed every six hours with Septisol and rinsed with 1:1000 aqueous Zephiran solution; the initially employed jelly was applied around the insertion of the catheter. In Group III, in addition, triclobisonium chloride vaginal suppositories were inserted every 12 hours until the catheter was removed. Final cultures were taken from the vagina, urethra and urine as soon as continuous drainage was discontinued.

## Results

In Group I a general increase of bacteria was demonstrated in the genitourinary system (Table 1). The same organisms were cultured from the vagina, urethra and urine in 38 per cent of the women. After use of the indwelling catheter, 96 per cent of the patients had one of the vaginal organisms in the urethra or urine. While 22 per cent of the urethral and 62 per cent of the urinary cultures were negative prior to use of the indwelling catheter, only 2 per cent of the urethral and 4 per cent of the urinary cultures remained negative after its use (Table 2).

Symptoms of cystitis, requiring treatment with sulfonamides and/or antibiotics, developed in 18 of 48 women in whom bacteriuria was present. Thirty-four women were considered morbid because of temperature elevations of 100.4°F. and over, which continued longer than 48 hours. Ten of these women routinely received 2 ml. of Combiotic®* twice daily for five days after surgery. Sixteen patients remained asymptomatic.

In Group II the number of patients having urethral bacteria was reduced within twelve hours. However, the vaginal bacteria were unaffected. No significant changes were found in the urine (Table 3). Following three or more days of continuous urinary drainage, the number of patients having microorganisms in the urethra and urine increased (Table 4).

Thirteen of 32 women having bacteriuria developed postoperative cystitis and required treatment. Temperature elevations of 100.4° and over were seen in 26 patients. Twelve of these were among 16 who routinely were given 2 ml. of Combiotic daily for five days.

The overall response to treatment was most favorable in Group III. A decrease was noted in the number of patients having vaginal and urethral bacteria (Table 5). There were no significant changes in the

* Pfizer Laboratories, Brooklyn, New York.

TABLE 1. *Vaginal, Urethral and Urinary Culture before and after Use of Lubafax — Group I*

| Organisms | Prior to Lubafax | | | After single Catheterization | | | After Foley Catheter | | |
|---|---|---|---|---|---|---|---|---|---|
| | Vagina | Urethra | Urine | Vagina | Urethra | Urine | Vagina | Urethra | Urine |
| No growth | 0 | 11 | 31 | 0 | 10 | 24 | 0 | 1 | 2 |
| Staph. albus | 23 | 12 | 7 | 24 | 13 | 12 | 32 | 18 | 17 |
| Staph. aureus | 8 | 8 | 2 | 8 | 8 | 4 | 14 | 10 | 8 |
| Non-hemol. Strep. | 7 | 3 | 3 | 7 | 3 | 3 | 13 | 5 | 5 |
| Alpha Strep. | 10 | 4 | 0 | 10 | 4 | 1 | 4 | 4 | 4 |
| Beta Strep. | 8 | 6 | 3 | 8 | 6 | 4 | 12 | 7 | 6 |
| E. Coli | 7 | 6 | 4 | 8 | 6 | 4 | 16 | 13 | 13 |
| Paracolobactrum | 5 | 1 | 0 | 5 | 1 | 0 | 7 | 3 | 3 |
| Aerobacter | 4 | 5 | 3 | 7 | 6 | 4 | 15 | 8 | 10 |
| Proteus | 2 | 1 | 0 | 2 | 1 | 1 | 7 | 2 | 2 |
| Pseudomonas | 0 | 0 | 0 | 1 | 1 | 0 | 4 | 2 | 2 |

TABLE 2. *Incidence of Vaginal, Urethral and Urinary Bacteria before and after Use of Lubafax*

| | VAGINA | | | | URETHRA | | | | URINE | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Negative | | Positive | | Negative | | Positive | | Negative | | Positive | |
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| Prior to Catheterization | 0 | 0 | 50 | 100 | 11 | 22 | 39 | 78 | 31 | 62 | 19 | 38 |
| After single Catheterization | 0 | 0 | 50 | 100 | 10 | 20 | 40 | 80 | 24 | 48 | 26 | 52 |
| After indwelling Catheterization | 0 | 0 | 50 | 100 | 1 | 2 | 49 | 98 | 2 | 4 | 48 | 96 |

urinary bacteria after continuous drainage for over a 72 hour period (Table 6).

Five of 28 women with bacteriuria developed cystitis and required treatment. Twelve women were considered morbid, four of whom had temperature elevations of over 101°F. None of this group routinely received antibiotics. It was noted that the healing of the vaginal vault was more rapid and complete in this group than in Groups I and II.

## Comment

Employment of the indwelling catheter for urinary drainage produced cystitis. Most organisms entering the urinary bladder from the vagina by way of the

TABLE 3. *Vaginal, Urethral and Urinary Bacteriuria before and after Use of Triclobisonium Chloride Lubricant — Group II*

| Findings | Prior to Triclobisonium Cl. | | | After single Catheterization | | | After Foley Catheter | | |
|---|---|---|---|---|---|---|---|---|---|
| | Vagina | Urethra | Urine | Vagina | Urethra | Urine | Vagina | Urethra | Urine |
| No growth | 0 | 11 | 25 | 20 | 36 | 30 | 0 | 22 | 18 |
| Staph. albus | 14 | 10 | 5 | 16 | 2 | 6 | 28 | 5 | 6 |
| Staph. aureus | 8 | 5 | 2 | 9 | 1 | 2 | 13 | 3 | 3 |
| Non-hemol. Strep. | 7 | 3 | 3 | 7 | 3 | 3 | 10 | 4 | 4 |
| Alpha Strep. | 11 | 3 | 1 | 10 | 1 | 1 | 6 | 2 | 2 |
| Beta Strep. | 7 | 6 | 2 | 6 | 2 | 2 | 9 | 3 | 2 |
| E. Coli | 10 | 8 | 5 | 8 | 2 | 5 | 15 | 4 | 7 |
| Paracolobactrum | 4 | 4 | 1 | 4 | 1 | 1 | 5 | 2 | 1 |
| Aerobacter | 9 | 7 | 4 | 8 | 2 | 4 | 14 | 5 | 6 |
| Proteus | 3 | 2 | 1 | 3 | 0 | 1 | 8 | 1 | 1 |
| Pseudomonas | 2 | 1 | 0 | 2 | 0 | 0 | 4 | 0 | 0 |

TABLE 4. *Incidence of Vaginal, Urethral and Urinary Bacteria before and after Use of Triclobisonium Chloride Lubricant — Group II*

| | VAGINA | | | | URETHRA | | | | URINE | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Negative | | Positive | | Negative | | Positive | | Negative | | Positive | |
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| Prior to Catheterization | 0 | 0 | 50 | 100 | 11 | 22 | 39 | 78 | 26 | 52 | 24 | 48 |
| After single Catheterization | 0 | 0 | 50 | 100 | 36 | 72 | 14 | 28 | 30 | 60 | 20 | 40 |
| After indwelling Catheterization | 0 | 0 | 50 | 100 | 22 | 44 | 28 | 56 | 18 | 36 | 32 | 64 |

TABLE 5. *Vaginal, Urethral and Urinary Bacteria Found before and after Use of Triclobisonium Chloride Vaginal Suppositories and Lubricant — Group III*

| Findings | Prior to Vaginal and Urethral Preparation | | | After single Catheterization | | | After Foley Catheterization | | |
|---|---|---|---|---|---|---|---|---|---|
| | Vagina | Urethra | Urine | Vagina | Urethra | Urine | Vagina | Urethra | Urine |
| No growth | 0 | 9 | 25 | 11 | 37 | 23 | 9 | 30 | 24 |
| Staph. albus | 18 | 9 | 7 | 12 | 5 | 7 | 15 | 7 | 5 |
| Staph. aureus | 4 | 2 | 2 | 3 | 0 | 2 | 2 | 0 | 1 |
| Non-hemol. Strep. | 5 | 4 | 5 | 3 | 3 | 3 | 5 | 5 | 4 |
| Alpha Strep. | 10 | 8 | 3 | 6 | 3 | 3 | 5 | 2 | 3 |
| Beta Strep. | 7 | 5 | 0 | 1 | 1 | 0 | 3 | 1 | 0 |
| E. Coli | 14 | 8 | 0 | 8 | 7 | 10 | 10 | 3 | 10 |
| Paracolobactrum | 5 | 4 | 0 | 3 | 2 | 0 | 1 | 0 | 0 |
| Aerobacter | 5 | 4 | 3 | 3 | 1 | 3 | 7 | 4 | 5 |
| Proteus | 3 | 1 | 1 | 1 | 0 | 1 | 2 | 0 | 1 |
| Pseudomonas | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |

TABLE 6. *Incidence of Vaginal, Urethral and Urinary Bacteria before and after Use of Triclobisonium Chloride Vaginal Suppositories and Lubricant — Group III*

| | VAGINA | | | | URETHRA | | | | URINE | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Negative | | Positive | | Negative | | Positive | | Negative | | Positive | |
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| Prior to Catheterization | 0 | 0 | 50 | 100 | 9 | 18 | 41 | 82 | 25 | 50 | 25 | 50 |
| After single Catheterization | 11 | 22 | 39 | 78 | 37 | 74 | 13 | 26 | 23 | 46 | 27 | 54 |
| After indwelling Catheterization | 9 | 18 | 41 | 82 | 30 | 60 | 20 | 40 | 24 | 48 | 26 | 52 |

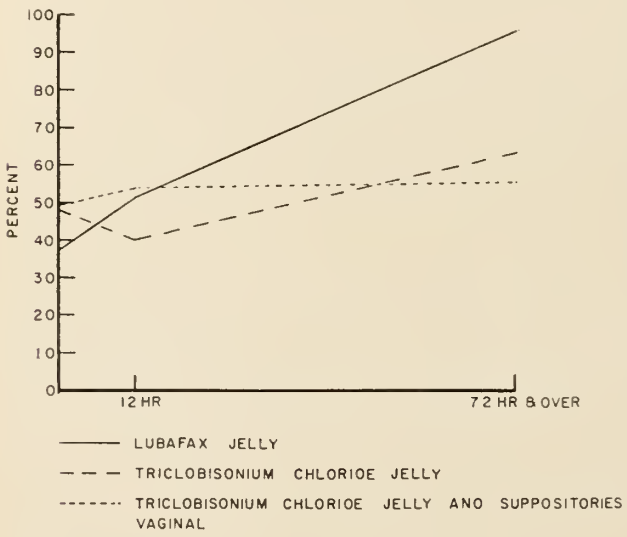



FIG. 1. *Incidence of bacteriuria after the use of Lubafax, after triclobisonium chloride lubricant, and after triclobisonium chloride lubricant and suppositories in catheterization.*

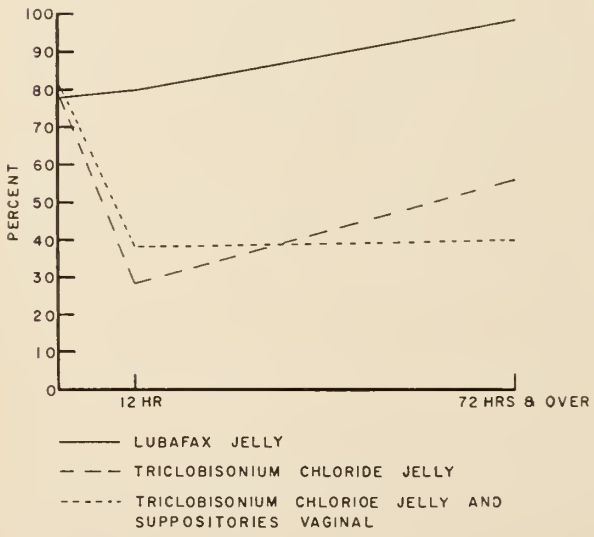



FIG. 2. *Urethral bacterial incidence after the use of Lubafax, after triclobisonium chloride lubricant, and after triclobisonium chloride lubricant and vaginal suppositories in catheterization.*

lymphatics and or the exuding urethral secretions were the same as those found in the vagina in many instances. It is known that traumatized tissue as well as the catheter, a foreign body, produce excellent culture media for bacterial growth. Systemic sulfonamides and antibiotic therapy probably depressed bacterial growth to some extent but did not eliminate the microorganisms as long as the indwelling catheter was employed.

It was evident that pre- and postoperative treatment of the vagina and catheter-urethral care decreased the number of bacterial invaders (figures 1 and 2) as well as the incidence of cystitis. This may be explained by the maintenance of the normal acid pH of the vagina, which postoperatively approaches neutrality or alkalinity, thus depressing the secondary bacterial invaders of the vagina, urethra and catheter. It is probable on the same basis that the vaginal lymphatic system remains relatively free of saprophytic organisms responsible for complications.

## Summary

1. It was demonstrated that the use of an indwelling catheter will increase the number of bacteria in the urethra and urine.

2. Neither urethral-catheter care nor systemic antimicrobial therapy will eliminate bacteriuria or cystitis.

3. An overall reduction in bacteria was observed in 50 patients who received pre- and postoperative vaginal and urethral-catheter care.

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# Comparison of Stained Urine Smear With Bacterial Colony Count

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THE ROLE of quantitative bacteriology in urinary tract infections is clearly defined.[1,2,3,5] It has been shown that urine colony counts of $10^5$ per milliliter and greater are usually associated with active urinary tract infections. Counts of less than $10^4$ per ml. are generally the result of contamination.[2,5] However, even with active infections the colony count may be reduced to less than $10^5$ per ml. by highly acid urine, very low specific gravity, antibiotics and chemotherapy.[1]

Kass[1] has pointed out that the uncentrifuged stained smear is positive for bacteria in 80 per cent of urines with a colony count over $10^5$ per ml. Sanford, et al.,[5] also felt that approximately $10^5$ organisms per milliliter had to be present before they could be seen on the centrifuged stained urine smear. This study correlates the stained urine smear and the colony count in patients with urinary infection.

Fifty patients with active, untreated urinary infections were studied. Urine was obtained by sterile catheterization in female patients and by collection of mid-stream, voided specimens in male patients. Quantitative and qualitative cultures were done in all patients within 24 hours after collection. Urines were refrigerated immediately until cultured. The quantitative colony counts were made by serial dilution of the urine and cultured on tryptone glucose yeast agar. The counts were made after 24 and 48 hours of incubation at 37.5°C. Stained smears of centrifuged and uncentrifuged samples of each serial dilution were examined for bacteria.

The colony counts were greater than $10^5$ per ml. in all these patients. They ranged from 1.5 by $10^5$ per ml. to 3.6 by $10^8$ per ml. The stained smears of all centrifuged undiluted urines were positive for bacteria. The organisms in all these smears were in a concentration of one or more per oil field. We consider that this concentration of bacteria in the stained centrifuged smear strongly suggests a colony count of over $10^5$ per ml. Other studies in our laboratory have shown that in over 300 colony counts of less than $10^5$ per mil., bacteria were found in the stained centrifuged smear in only 5.6 per cent.[4] In all of these, the concentration of organisms on the stained smear was less than one per oil field. It is also characteristic of such stained smears that bacteria frequently are associated with epithelial cells or that they occur in a few areas in large aggregates, with most parts of the smear free of bacteria.

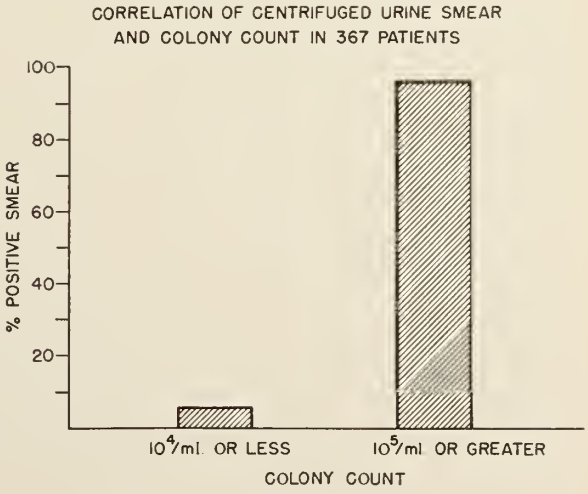



FIGURE 1.

All uncentrifuged undiluted urine smears in the present study contained bacteria. However, in 12 per cent of these patients, the concentration of organisms was less than one per oil power field. It

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From the Department of Surgery (Urology), Ohio State University Health Center. Submitted September 13, 1961.

This study was supported in full by funds from the Comly-Coleman Fund.

COMPARISON OF UNCENTRIFUGED AND CENTRIFUGED STAINED URINARY SMEARS IN FIFTY PATIENTS WITH ACTIVE URINARY TRACT INFECTION

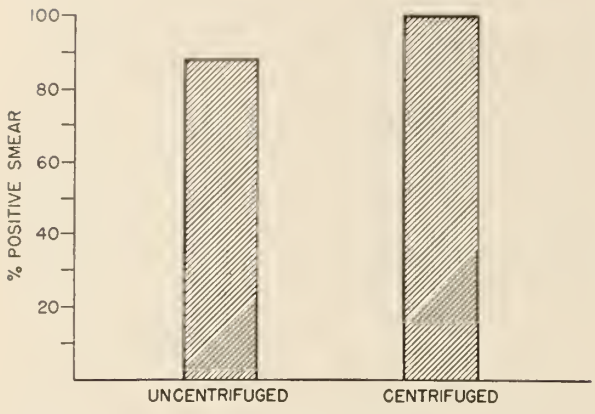



FIGURE 2.

appears that the centrifuged urine smear reflects the degree of bacteriuria somewhat more accurately than does the uncentrifuged smear. Comparison of the smears of the centrifuged and uncentrifuged serial dilutions indicated that centrifuging infected urine concentrates 10 times as many organisms on the smear.

## Summary

1. The centrifuged stained urinary smear correlates well with the urine colony counts.

2. Bacteria on the stained smear in concentrations of less than one per oil field, or in association with epithelial cells are suggestive of colony counts less than $10^5$ per milliliter.

3. The centrifuged urinary smear more accurately reflects the degree of bacteriuria than does the uncentrifuged smear.

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SUICIDE AND SUICIDAL ATTEMPTS are not rare in children and adolescents. The author believes that suicidal thoughts and attempts are either ignored or undervalued in such individuals because of the erroneously accepted tenet that they do not become depressed. Once we can successfully recognize signs by which depression is manifested in younger persons, we will be in a position to prevent many serious suicidal attempts.

A review of statistics from Bellevue Hospital for 1960 revealed that of about 900 admissions to the children's and adolescent services, 102 were for suicidal attempts and threats. Of the 102, 18 (7 females and 11 males) were under 12 years of age, and 84 (74 females and 10 males) were from 12 to 17 years of age. The majority were adolescent females, who were diagnosed as having character disorders and were reacting to stressful situations. The majority came from chaotic home situations where one or both parents were absent.

Most of the youngsters were described as having behavior and character disorders. They were immature and impulsive, and they often reacted excessively to stresses, even of a minor nature. When they were studied in more detail, they showed many symptoms of depression: restlessness, boredom, compulsive hyperactivity, sexual promiscuity, truancy, behavioral difficulties at home, running away from home, feelings that no one cares for them, accident proneness, masochistic actions, self-destructive behavior, excessive fatigue, hypochondriacal preoccupation, difficulty in concentration, and feelings that they are bad, evil and unacceptable.

It is the author's theory that the common denominator in all depressive reactions is loss of the love object; this was found in many of the children and adolescents reported in this paper. Unlike the findings reported by Balser and Masterson, when they reviewed the records of 500 adolescents, schizophrenic individuals did not predominate in the author's study.

Case histories illustrate the following causes for suicidal attempts: (1) anger at another that is internalized in the form of guilt and depression, (2) attempts to manipulate another (to gain love and affection or to punish another), (3) attempts to call attention to personal problems and receive help, (4) reactions to feelings of inner disintegration, or (5) a desire to join a dead relative.— ABSTRACT: James M. Toolan, M. D., New York: Suicide and Suicidal Attempts in Children and Adolescents, *American Journal of Psychiatry,* 118:719-724, (February) 1962.

# Anabolic Agents and Childhood Growth

## Discussion of Growth Phases and Significance Of Appropriate Therapy

ORVILLE C. GREEN, M.D.

CHILDHOOD growth may be divided into three general phases: an intrauterine phase, a growth hormone phase, and an adolescent phase. Each phase has its own specific stimulus; each phase has its own characteristics. The anabolic stimulus causing intrauterine growth is actually unknown, and little productive research is going on in this field. Yet this stimulus is the most potent anabolic stimulus known to medical science: two microscopic cells, an ovum and a sperm, unite and in the short period of nine months there results a 7½ pound, well differentiated, functional mass of tissue known as the human neonate. This rate of growth exceeds that of most cancers, and yet it is so well controlled that 95 per cent of all newborns are similarly phenotypically formed and function in predictable ways.

There is accumulated evidence to demonstrate that this rate of growth is independent of the endocrine system as we know it. Anencephalic neonates are full size in all respects except the cranium[1]; at least one hypophysectomized mother has given birth to an infant of normal size for gestational age[2]; infants born of acromegalic mothers are of normal size[3]; the only endocrine disorder that may cause large babies is maternal diabetes mellitus. Here again, the cause is obscure.

After the infant is separated from the placenta, this great stimulus to growth tapers off. Growth charts show this deceleration, and a simple rule of thumb has arisen. The newborn grows 10 inches in the first year, by accumulation of four inches the first three months, three inches the second three months, two inches the third three months, and one inch the last three months. This deceleration is observed in all children, even those later diagnosed as "hypopituitary." Clinical evidence suggests that between the ages of 1 and 3 years, the infant enters upon his second phase of growth, controlled by growth hormone.

### Childhood Growth Phase

Our knowledge of the effects of pituitary growth hormone has increased greatly in recent years. Researchers had been puzzled to find that extracts of animal pituitary glands were active in the human with respect to gonadotrophic, thyrotrophic and adrenocorticotrophic activities, but no pure growth hormone effect was observed. With the recent demonstrations that growth hormone is species-specific for primates,[4,5] knowledge has accumulated rapidly, and isolation of active hormonal substances from the glands of primates has resulted in a number of studies on children.[4,5,6,7,8,9]

The chief obstacle is the short supply of this hormone. Only about 750 mg. of active growth hormone can be obtained from 200 human pituitary glands.[6] This would provide for 150 days of therapy giving 5 mg. daily, or 367 days of therapy giving 2 mg. daily. Evidence suggests that the lower dose stimulates a normal growth rate, but it is immediately apparent that a great number of glands, as well as considerable expense, is involved in treating one child deficient in growth hormone for a period of one year. The result will be a height increment of 3 inches.

A review of growth hormone therapy in three of the first reports in children is interesting. Raben treated a 17 year old hypopituitary male, whose height age was 8 years.[7] In a 10 month period, this individual grew 2.1 inches. Significantly, there was no change in bone age; the rate of skeletal maturation was not increased. Hutchings also reported therapy in an 11½ year old female with the diagnosis of hypopituitarism and a height age of 6 years.[8] In a nine month period there was a growth of 3.6 inches on dosages of 2.5 to 10 mg. per day. Again, there was no change in the rate of skeletal maturation. Shepard produced a growth of 3.75 inches over a period of 10 months in a 3½ year old hypopituitary

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male.[6] There was no increase in the rate of skeletal maturation, but he noted an apparent increase in the zone of provisional calcification at the epiphyses.

Balance studies in these patients demonstrated positive balances for nitrogen, potassium, sodium, calcium, and phosphorus. Growth hormone produced a rise in the non-esterified serum fatty acids, suggesting a mobilization of fat depots to provide energy sources. Fasting blood sugars were not significantly altered, and three hour glucose tolerance curves were not "diabetic," although one case demonstrated abnormally high one and two hour levels. The changes in serum alkaline phosphatase and serum phosphorus were variable, and no conclusions were possible. This is interesting since earlier work had suggested that the drop in serum phosphorus seen at maturity might be due to a "shutting off" of growth hormone in the body.[10] Recently immunological assay techniques have demonstrated that growth hormone does circulate in the adult,[11] and probably plays a role in fat utilization, causing a rise in serum non-esterified fatty acids similar to that seen in children.[5]

Human growth hormone has been given to children with other growth disorders. In gonadal aplasia no effect on growth is observed.[12] Plasma assays for growth hormone in gonadal aplasia have actually demonstrated a high circulating level, comparable to that found in acromegaly, suggesting that these children are unresponsive to its effects, and that their genetic abnormalities determine their ultimate height.[13] In the "primordial dwarf," where growth is impaired but the rate of skeletal maturation is normal, growth hormone has no effect in stimulating growth.[12] Again, one must assume that these individuals are genetically unresponsive to the normal growth stimuli. Indeed, many of these children in this category have demonstrated an unresponsiveness to the very potent intra-uterine stimulus, for some are dwarfed at birth. These children have caused considerable confusion in newborn nurseries where rigid criteria have forced all neonates weighing less than 2500 grams into the premature nursery, in spite of maternal insistence that the gestation period was the full nine months.

Growth hormone administration to achondroplastic dwarfs has produced no growth effects.[12] Administration to premature infants, already under the most potent intra-uterine growth stimulus, has likewise been unsuccessful in stimulating a more rapid growth.[14] Finally, administration of large doses of human growth hormone to a child with idiopathic hypoglycemia of infancy has been unsuccessful in altering the disordered glucose homeostatic mechanism.[15]

In summary, it appears that growth hormone is species-specific in its growth stimulating effect in the human. It causes a positive nitrogen balance, it mobilizes fat and spares protein in energy utilization, but it does not cause an inappropriate rate of skeletal maturation when growth is stimulated.

### Adolescent Growth Phase

The third and last phase of childhood growth is initiated by an unknown trigger mechanism resulting in gonadotrophin secretion. Adrenal and gonadal maturation produces a flow of androgenic and estrogenic compounds in both sexes. There is a spurt of growth, with rapid skeletal maturation and consequent fusion of epiphyses. With this fusion, growth ceases. One of nature's experiments provides us with a lesson as to the effects of an inappropriate androgenic stimulus at an early age. In congenital adrenal hyperplasia, an adolescent steroidal growth spurt from the time of birth is superimposed on the growth hormone phase of growth. The results are seen as a rapid rate of growth, with side effects of "virilization" (see Chart 1). One of the most devastating side effects

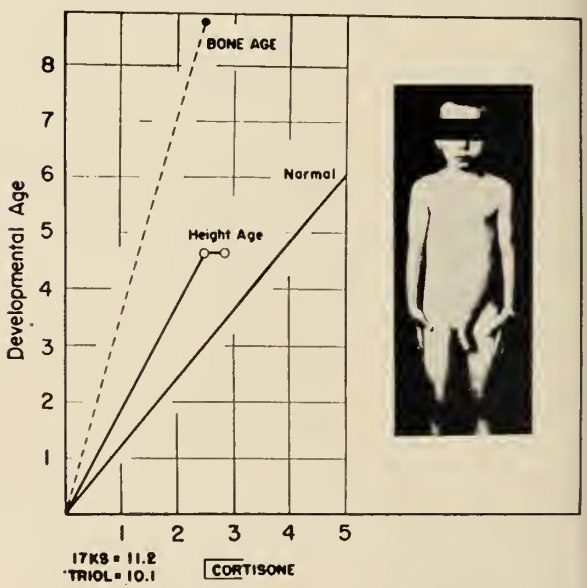



CHART 1. *Effect of circulating adrenal androgens in untreated congenital virilizing adrenal hyperplasia. Two and one-half year old boy with height age of four and one-half years and bone age of eight and three-fourths years.*

in the untreated cases is the extremely rapid rate of skeletal maturation that is the result of the presence of circulating androgenic steroids. In untreated cases, it is significant that the "skeletal age" always exceeds the "height age" in its rate of advance, and when fusion occurs, the child is left dwarfed in comparison to normal adult height attainment.

A great therapeutic advance was achieved when Wilkins discovered that cortisone administration would shut off the adrenal stimulus and permit these children to grow normally, with the skeletal age held in check by removal of the androgenic stimulus.[16] This discovery by Wilkins was no accident; he had been studying numerous steroidal compounds and their effects in the body.[12] He concluded that steroids of androgenic structure, irrespective of added methyl or ethyl groups, or other molecular alterations, would

invariably produce associated anabolic and virilizing effects.

Recently chemists have again begun to alter the steroid molecule in an attempt to alter physiologic effects in the human body. Numerous new androgenic analogues have appeared on the market in the 15 year interval since Wilkins studied similar compounds. The major change has been the absence of the methyl group at position 19 on the steroid nucleus. "19-nor" has become the modern shorthand term for these compounds (No-R at 19). Nilevar®, Norlutin®, 19-nor-methyltestosterone, Anadrol®, are a few of the available compounds. In addition, Dianabol® is available as a more potent form of methyltestosterone.

It is claimed that these drugs demonstrate separation of anabolic and virilizing effects in the body. Analyses to support this contention have been presented by analogous studies in rats, demonstrating variable effects on seminal vesicle enlargement and growth of the levator ani muscle. Such studies may have some relationship to use in adult humans. For use in children, we must recall that all these compounds are steroidal in origin, and their biological effects would be expected to be similar to the steroidal growth phases seen in the adolescent or the child with untreated congenital virilizing adrenal hyperplasia. These growth phases are accompanied by rapid acceleration in skeletal maturation, as well as growth in length of the long bones. There is no experimental evidence to demonstrate that steroids may accomplish increase in long bone length without a rapid advance in skeletal maturation, as is accomplished with growth hormone therapy.

What is the result when various steroidal analogues are administered to growing children? Three examples are presented in the accompanying charts. Chart 2 shows the effect on skeletal maturation in a 12 year old boy with the tentative diagnosis of hypopituitarism. With therapy, the delayed skeletal age shows a rapid maturation; the change in height increments is less impressive.

Chart 3 shows the effect of the administration of $\Delta$-1-methyltestosterone to a 9¾ year old boy with a craniopharyngioma. For nine months after surgery, he had been maintained on replacement thyroid and cortisone management. He was then given this drug in an attempt to evaluate its growth effect. The chief effect was a rapid appearance of new calcified epiphyseal centers, which we define as a rapid rate of skeletal maturation. The effect on height was negligible.

Chart 4 shows the effect of Anadrol, another new drug now available. This drug was administered for 18 months in low dosage to a 4½ year old boy with

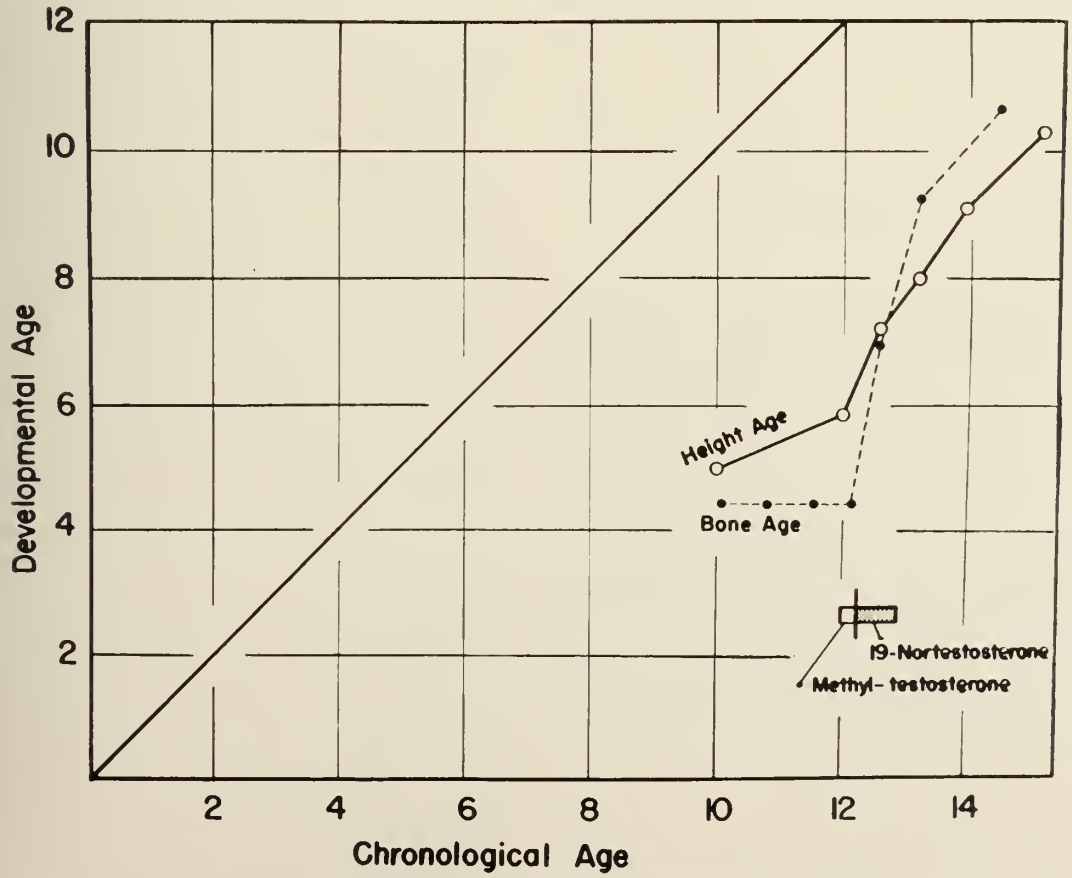



CHART 2. *Effect on skeletal maturation in a 12 year old boy with diagnosis of hypopituitarism when 19-nortestosterone is administered for six months.*

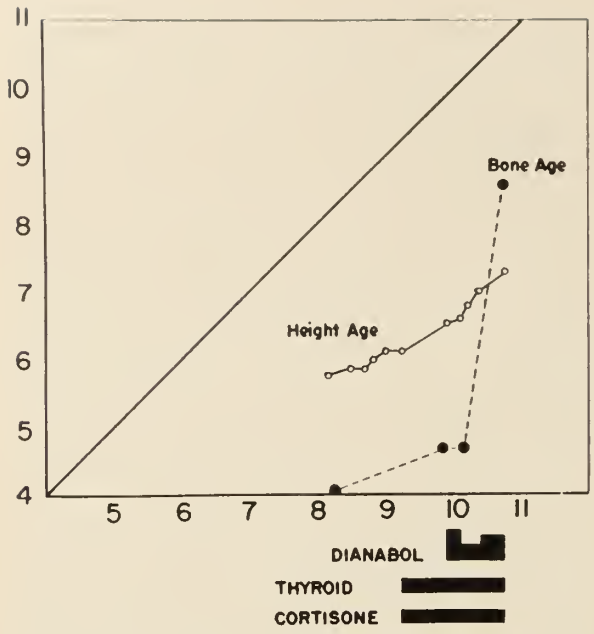



CHART 3. *Effect on skeletal maturation when △-1-methyltestosterone is administered to a 9¾ year old boy with craniopharyngioma. Dosage variation from 2 to 5 mg. per day in a period of one year.*

the tentative diagnosis of hypopituitarism. No remarkable change in his rate of growth is apparent until the rapid advance in skeletal maturation appears in the last six months of therapy. Once more, we see an inappropriate advance of the skeletal age relative to the height increment achieved. Clinics elsewhere have studied fluoxymesterone. Recent reports have demonstrated that this drug also, when administered to young children, will cause an inappropriate advance in skeletal maturation, out of proportion to the achieved height increment.[18] All of these steroidal

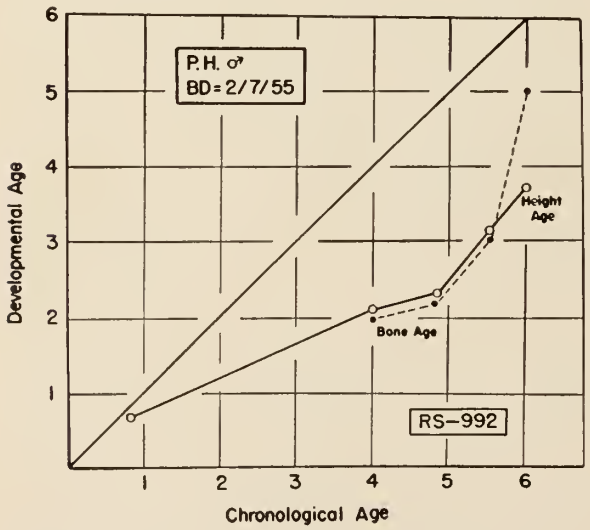



CHART 4. *Effect of administration of anabolic steroid Anadrol administered for a period of one year to boy with tentative diagnosis of hypopituitarism. Dosage for first four months of 15 mg. daily reduced to 10 mg. daily for eight months.*

preparations have the ability to stimulate growth, but they seem to do so by rapidly advancing skeletal maturation. The first study to document this skeletal effect of chemically altered steroids was published by Sobel et al. in 1956, and demonstrated that methyltestosterone was a potent anabolic agent but should not be utilized for growth effects in young children.[19] The evidence previously quoted demonstrates that newer analogues have not altered this conclusion.

## Summary

Steroid anabolism is accomplished through biochemical effects in the body greatly stimulating protein synthesis. Studies suggest that growth hormone has a protein sparing effect through its mobilization of fat for energy. Normal childhood growth is achieved by these two different biochemical mechanisms at different specific times. The former compounds are not substitutes for the latter, and their use in children must be carefully observed for the predictable effects on skeletal maturation.

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# Sweat Collection in Cystic Fibrosis

## Report of a Simplified Method Employing Pilocarpine Iontophoresis and Cellulose Sponge*

CHARLES A. COLTMAN, JR., Captain, USAF (MC), and ROBERT J. ATWELL, M. D.

SINCE the discovery of elevated concentration of electrolytes in sweat of children with cystic fibrosis, many techniques for the collection of sweat samples have been described. In conducting recent investigations, we have combined two earlier published techniques, pilocarpine iontophoresis[1] and the cellulose sponge method for collecting sweat,[2] to allow for rapid collection and analysis. Because of the simplicity of the technique and the increasing interest in this syndrome in adult medicine, we have elected to report our results.

### Materials and Methods

A modification of the iontophoresis apparatus,** as described by Gibson and Cook,[1] was devised (Fig. 1 and Fig. 2). It derives its current from either a dry cell battery or 120 volt A. C. current by way of a selenium rectifier, thus preserving battery life when an A. C. source is available. Their alternative procedure with 3 inch by 3 inch electrodes, and 4 ml. of 0.2 per cent pilocarpine nitrate solution was employed. Iontophoresis was carried out at 4 ma. setting for 15 minutes. A collection sponge (Fig. 1)† was applied and covered with Saran Wrap held by adhesive tape. The collection period averaged 30 minutes. The sponge was then removed from the forearm, placed in a 5 ml. syringe, and the whole sweat extracted by compression of the plunger. Sweat was analyzed for chloride by the Schales and Schales[3] technique, which requires a 0.1 to 0.2 ml. sample. The procedure is quite simple, requiring but three reagents and a 1cc. pipet, which can be read to 0.01 ml., for the titration.

Patients numbering 400 were obtained from the Ohio Tuberculosis Hospital and University Hospital clinics. Twenty-three persons previously reported by Peterson[2] were re-tested by iontophoresis to compare the bag and iontophoresis techniques.


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● **Dr. Atwell, Columbus, is associate professor, Department of Medicine, The Ohio State University College of Medicine.**


### Results

Four hundred sixteen tests were done on 400 persons. Sixty-two samples, or 14.9 per cent, were considered insufficient for analysis because less than 0.1 ml. of whole sweat was obtained.‡ The average volume of the sample was .348 ml., with a range of 0.0 to 2.01 ml. By weighing the sponges from which



FIG. 1. *Photograph of modified iontophoresis apparatus showing 3" by 3" electrodes and collection sponge in foreground.*

*From the Department of Medicine, The Ohio State University College of Medicine, Columbus, Ohio. Submitted August 17, 1961.
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The contents of this paper reflect the personal views of the authors and are not to be construed as official Air Force policy.

**Parts furnished by Hughes-Peters Company, Columbus, Ohio, at a cost of $18.12.

†Sponges were manufactured to our specifications by the American Sponge and Chamois Company, Long Island 1, New York, and measure 2 5/8" by 2 3/4" by 1 mm. in size.

‡As a result of the fairly high incidence of small samples (less than 0.1 ml.) we employed the ultramicro adaptation of the method of Schales and Schales for analysis of chloride, using the Beckman/Spinco Model 150 Ultramicro Analytical System. This technique requires a 10 microliter sample. Now adequate samples are obtained in 97.65% of tests.

the maximum amount of whole sweat had been expressed, before and after drying, we found that an average of 0.164 ml. of sweat had been left in the sponge. A solution of known saline concentration was added to several sponges and it was shown that the sponges did not significantly alter the chloride concentration.

Of the 23 determinations on patients previously reported by Peterson,[2] using the bag technique, the results by iontophoresis compared favorably. They were within ±10 milliequivalents per liter in 14 of the 23, and ±15 milliequivalents per liter in 19 of the 23. Known normals and abnormals were tested with results similar to those previously obtained. Infants and small children were successfully tested using the outer aspect of the thigh for the collection site. No untoward local or systemic reactions were encountered.

## Comments

This technique has proved to be quite easy and reliable and it has several advantages over established techniques. There is no stressful use of sweat bags. The test has been performed on adults and children with equally good results. The use of the cellulose sponge reduces by 50 per cent the technical time,[2] as well as the sources of error, associated with weighing and elution of sweat in the gauze technique. An analytical balance is not required. Adequate specimens may be obtained in 85 per cent of patients. The equipment and time necessary for collection and analysis of chloride is very minimal, making the test feasible for use in the physician's office laboratory. Using an ultramicro technique for the analysis of chloride, it is possible to collect a satisfactory sample of pure sweat on nearly all patients.

## Conclusion

A combination of two previously described techniques for the collection of sweat electrolytes is described. This method combines the advantages of both and presents a rapid, simple approach to the screening of large groups of patients for this exocrine aberration.

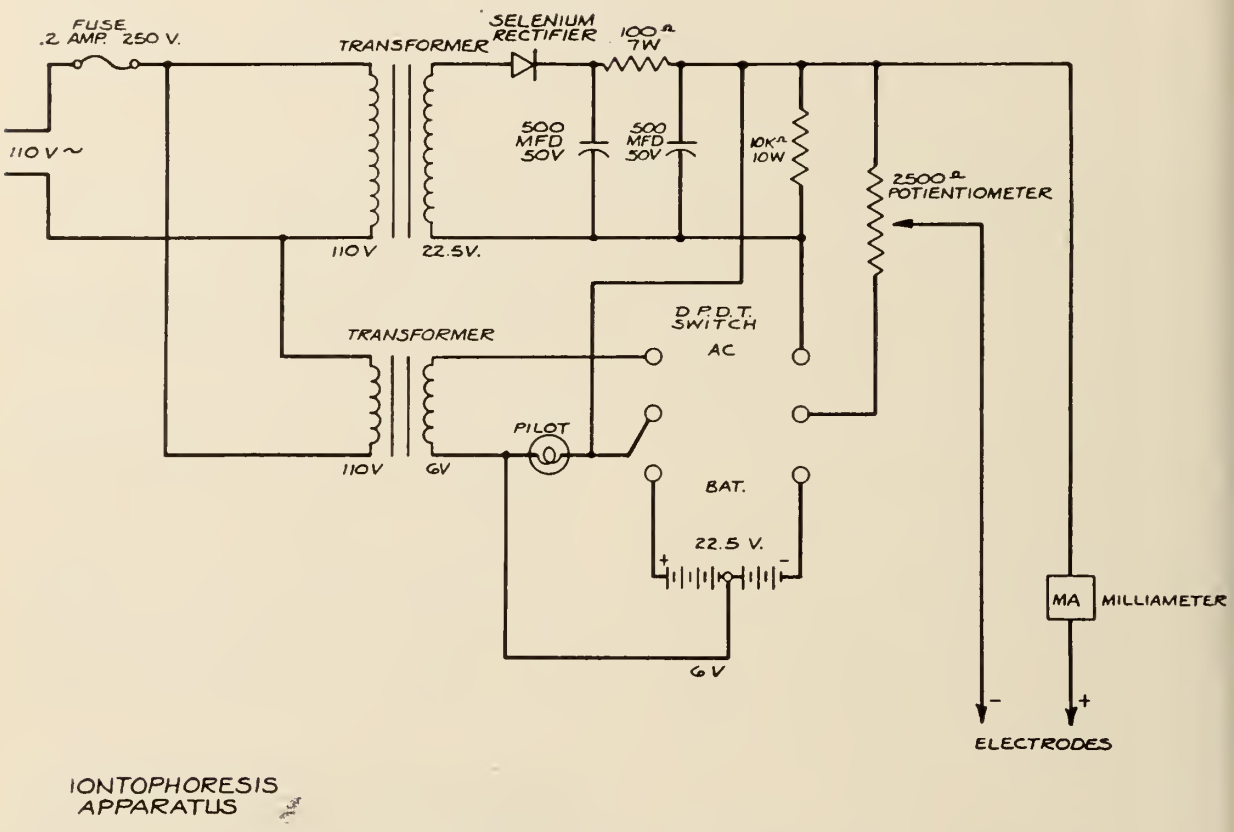



FIG. 2. *Wiring diagram for the modified iontophoresis apparatus using either A. C. or D. C. source.*

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## Innocent Murmurs

As in the case of the accomplished musician who perceives more of the music he hears than does another, the training and experience of a physician weigh heavily in his evaluation of a murmur. — Dale Groom, M. D.: *Southern Medical Journal*, 54:253-256, March, 1961.

# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT P. CARSON, M. D., *President*

### CASE PRESENTATION

THIS 62 year old white man, operator of a dry-cleaning establishment, had enjoyed active good health until 14 months prior to admission when he began having orthopnea and paroxysmal nocturnal dyspnea for which he was digitalized. He did well until seven months prior to admission, when he had bronchopneumonia associated with a single episode of hemoptysis. Three months prior to admission he developed more fatigue and symptoms of heart failure, which again responded to therapy and hospitalization. Two months prior to admission he developed dependent edema without other signs of congestive failure. At this time he noted loss of appetite, which persisted. He became progressively weaker and more fatigued. Two weeks prior to admission petechiae were noted over the trunk and lower extremities. Three to four days prior to admission he noted that his urine had become dark. Two days before admission he noted paresthesias and definite weakness in the right arm and hand.

His past history revealed that he had had rheumatic fever at the age of 13 years, characterized by migratory painful, swollen joints. He was known to have had a heart murmur all his adult life.

#### Physical Examination

His blood pressure was 110/80, pulse rate 80 per minute, respiratory rate 22 per minute, and temperature 97.6°F. He was a thin, weak man who appeared chronically ill. There were diffuse muscle wasting and atrophy. Mild periorbital edema and exophthalmos were noted bilaterally. The sclerae were icteric and the fundi were normal. The tongue was markedly furrowed and bright red; there were 1-2 mm. ulcerations along the alveolar ridge and multiple petechiae on the buccal mucosa, palate and pharynx. The lungs were clear to percussion and auscultation. The heart was enlarged to the anterior axillary line. The apical rhythm was irregular with multiple premature contractions; there was a grade 3 high-pitched systolic murmur heard in the mitral area; a diastolic gallop was present. A firm, smooth, slightly tender liver edge could be felt two fingerbreadths below the right costal margin.

There were multiple ecchymotic lesions and petechiae over both lower extremities. There was 3 plus pitting edema of the feet and legs. Neurological examination showed diffuse scattered muscle fasciculations; there was weakness of the right arm with presence of drift and past-pointing; the deep tendon reflexes were absent throughout. There was no sensory deficit.

#### Laboratory Data

The hemoglobin was 17.2 mg. with a hematocrit of 63 per cent; white blood cell count was 8,650 with 72 per cent polymorphonuclear leukocytes, 26 per cent lymphocytes, 1 per cent eosinophils and 1 per cent basophils. Sedimentation rate was 0. Urinalysis showed a specific gravity of 1.016; protein was 320 mg. per 100 ml.; the sediment contained 0-3 white blood cells and 3-6 red blood cells per high powered field. Alkaline phosphatase was 12 units. The van den Bergh was 2.8 mg. per 100 ml. direct, 4.0 mg. total. Cephalin flocculation was 2 plus; thymol turbidity was less than 5 units. Albumin was 2.2 Gm. per 100 ml. and globulin 3.1 Gm. Blood electrolytes were normal. The blood urea nitrogen was 41 mg. per 100 ml. The van den Bergh progressively rose and on the sixteenth hospital day was 6.1 mg. direct, 8.5 mg. total, and the alkaline phosphatase at that time was 18 units. Over the course of hospitalization the blood urea nitrogen fell to the range of 20 mg. Twenty-four hour radioactive iodine uptake by the thyroid was 9 per cent. Multiple

### *Presented by*

- Samuel Saslaw, M. D., Columbus;
- Emmerich von Haam, M. D., Columbus, and
- Leopold Liss, M. D., Columbus

Edited by Dr. Von Haam.

Submitted March 29, 1962.

blood cultures remained negative throughout hospitalization.

Chest x-ray on admission showed diffuse cardiomegaly with particular predominance of the left ventricle, and a left pleural effusion. Electrocardiogram showed an incomplete left bundle branch block, multiple premature ventricular contractions and low voltage in the limb leads. Electroencephalogram showed diffuse encephalopathy.

### Hospital Course

Following admission the patient remained weak and lethargic. Treatment with digitalis was continued. His blood pressure fell and he was started on Solu-Cortef® intravenously. He seemed to improve somewhat; however, rales persisted in both bases. The petechiae on the lower extremities persisted. He was started on intravenous penicillin, 4 million units per day. An audible electromyogram was interpreted as showing diffuse neuropathic disease. Throughout this time his peripheral edema continued without appreciable change. His appetite was quite poor and his intake was supplemented each day with intravenous fluids.

On the tenth hospital day he complained of right upper quadrant pain and on examination showed tenderness over the area of the liver. His appetite continued to be poor and he developed a thrush infection of his mouth. He seemed to be weaker and more lethargic, and he was treated with tube feedings. A lumbar puncture was done which showed an opening pressure of 240 mm. of water; the fluid was clear yellowish and showed 12 red blood cells, no white blood cells, 26 mg. of protein and 172 mg. of sugar per 100 ml. On the eighteenth hospital day his temperature rose to 102° rectally; there were rales in both bases with diminished breath sounds, most marked over the area of the right lower lobe. At this time he was producing thick green sputum which on culture grew out a coagulase positive staphylococcus and an enterobacillus. He continued to have marked diffuse muscle weakness and fasciculations. Muscle and skin biopsies were obtained from the right biceps area. The pathologist interpreted the muscle biopsy as showing a necrotizing myositis. The skin biopsy was normal. He was treated with tetracycline and streptomycin but continued to deteriorate. He became more icteric, progressively weaker and more lethargic and less responsive. He died quietly on the twenty-fourth hospital day.

## CLINICAL DISCUSSION

DR. SASLAW: This man was a 62 year old white male operator of a dry-cleaning establishment. I could stop right here and ask whoever prepared the protocol to give me a more detailed history. How long had he been in the dry-cleaning business? Was he a big operator who let other people work with the fumes? or was he a small operator who was in there doing the work himself? We will just have to keep in the back of our minds a variety of toxic or sensitizing factors which might link this occupation with the clinical picture.

This man was apparently in pretty good health up until this present episode 14 months before admission. At the age of 13 he had definite rheumatic fever, and he was known to have a heart murmur all his life. But apparently he got along pretty well up until 14 months ago. Then he started out with orthopnea and paroxysmal nocturnal dyspnea, which spell heart failure. This might happen to almost any individual at this age, particularly an individual who had some underlying heart disease, but apparently he responded pretty well to digitalis and had no further difficulty until seven months ago when he really started to go downhill. He had bronchopneumonia associated with a single episode of hemoptysis which required hospitalization. Later he was hospitalized again because he had more fatigue, and one month later he appeared with edema and anorexia, which apparently persisted from here on out to the very end. Two weeks before admission he noted petechiae on his trunk and extremities, and then three to four days before admission he started to show some neurological manifestations.

Obviously being very ill, he was admitted to this hospital and showed some remarkable things on physical examination. He was thin, weak, chronically ill, and icteric. Also it was noted that he had had diffuse muscle wasting and some exophthalmos. He had an enlarged heart with a grade 3 systolic murmur in the mitral area. So we have a sick man here with neurological manifestations, petechiae, heart and liver involvement and generalized evidence of severe systemic deterioration.

The laboratory tests tell us that he had probably some hemoconcentration. His urine showed severe albuminuria with a few white blood cells and a few red blood cells. His alkaline phosphatase and van den Bergh were elevated, and he had a reversed A/G ratio. Multiple blood cultures remained negative throughout his hospitalization. An encephalogram showed diffuse brain disease.

In the hospital the patient apparently kept getting weaker, more lethargic, and his blood pressure started to fall, requiring vasopressors to maintain it. He began to run fever, developed rales in both bases and had a purulent sputum. Obviously he was developing pneumonia. He was treated with all kinds of antibiotics but continued to deteriorate, became yellower, weaker, more lethargic, and quietly died on the twenty-fourth day.

### Differential Diagnosis

Let's discuss now those factors which we would want to consider in the differential diagnosis and eliminate those which did not contribute to his disease. First of all, could intoxication from his occupation have been a contributory factor? We don't know the type of exposure he had and if carbon

tetrachloride was involved. We know that patients with carbon tetrachloride poisoning can have abdominal symptoms, but we attribute his abdominal symptoms more to liver engorgement. I would also be hesitant to think of benzene intoxication since he did not show depression of his bone marrow.

Then in view of the fact that some thyroid studies were done on this patient, the problem of thyrotoxicosis comes up for consideration. Although patients with thyrotoxicosis may lose a lot of weight, their appetite does not suffer much, and this man had complete anorexia. We know that thyrotoxicosis may masquerade frequently under the symptoms of heart failure which is refractory to all sorts of therapy, but this fellow apparently responded pretty well to digitalis. The only thing that might suggest thyroid disease is his mild exophthalmos. However, eye signs are usually absent in patients who develop muscular weakness on the basis of thyrotoxicosis. Finally, I think that his petechiae and his other symptoms pretty well permit us to eliminate thyrotoxicosis from his picture.

We could go into a broad discussion of all the primary and secondary muscle diseases and spend the rest of the period eliminating them one after another. First I may state that we have no evidence of a lot of mental deterioration which goes with some of the demyelinating diseases. The fasciculations point to an inflammatory disease, and his electromyogram (EMG) studies could be consistent with polio or other anterior horn disease, but the severity of his symptoms speaks against anterior horn involvement.

### Not S. B. E.

I want to move on to another possibility which I think also must have been considered very strongly here and this would be subacute bacterial endocarditis. He had the petechiae, and his weakness and parasthesias may be interpreted as phenomena of focal embolization. We know that the signs and symptoms of endocarditis usually are associated with signs of infection, evidence of cardiac disorders and embolic phenomena. The fact that he had negative blood cultures does not necessarily rule it out. But at this stage of the game I would have expected fever to be a more predominant sign, and from the laboratory standpoint, even with negative cultures, I would have expected a little more anemia. Therefore I am not inclined to consider bacterial endocarditis as his principal disease.

### Collagen Disease

Finally, in a case with fever of undetermined origin, skin lesions, neurological manifestations, and anything else that suggests multisystem disease, we always have to think of the group of collagen diseases. Let us see which of them could fit the picture presented by our patient. Certainly lupus erythematosus can produce any symptoms that this patient had since it is a multisystem disease. The principal argument against lupus would be the absence of lupus erythematosus cells, but that again does not rule it out. Also the patient was a male and not a female, and he had a unilateral pleural effusion while lupus usually produces bilateral effusions.

How about dermatomyositis? In the few cases of dermatomyositis we have seen we have been impressed that these people come in with the chief complaint of weakness. We have had patients who even had to be placed in respirators because of their weakness, and they usually develop pneumonia and die in the same manner our patient died. But in dermatomyositis neither the pleura nor the kidneys are usually involved, and we have evidence that this patient may have had some early renal involvement. Furthermore the skin biopsy was negative, which again does not completely rule out this disease.

I think the collagen disease which we may have to consider as the most likely possibility in this case is polyarteritis nodosa. The man had all the multisystem disease that can go with this condition. He had the skin lesions and muscle lesions that go with it and all the evidence of multiorgan involvement. In addition there is the possibility that he may have been sensitized either from his occupation or from the therapy he had in that initial bout of pneumonia seven months prior to his admission. He apparently did not have severe enough or long enough renal involvement to become hypertensive, as those patients usually do. Neither does the lack of eosinophils rule it out, although a peripheral eosinophilia permits us to make the diagnosis with greater certainity. Whether it is the usual idiopathic type of polyarteritis or the hypersensitivity type of angiitis described by Zeek would be a little difficult to decide, so I suggest that we call it just polyarteritis and let it go at that.

In conclusion, I would like to say that this patient had multisystem disease and that his heart failure which developed during his disease may have represented the first manifestation of his condition. As a final blow he developed pneumonia, of which he died. We would be inclined to say that we would expect polyarteritis with involvement of the heart, lungs, brain, kidneys and liver. Whether he had had rheumatic fever before is hard to say, but I see no reason to be too emphatic that he did not have an old rheumatic valvulitis. I don't think that his rheumatic disease shows any activity and I would consider it just the underlying disease.

### CLINICAL DIAGNOSIS

1. Polyarteritis, type undetermined.
2. Confluent bronchopneumonia of left lung.
3. Old rheumatic heart disease with mitral valve involvement.

*(Continued on Next Page)*

*(Continued)*

PATHOLOGICAL DIAGNOSIS

1. Active rheumatic heart disease with severe congestive failure.
2. Confluent bronchopneumonia of left lung.
3. Thrombo-endarteritis of pulmonary vessels with multiple pulmonary infarction.
4. Creutzfeldt-Jakob disease.

PATHOLOGICAL DISCUSSION

Dr. von Haam: The autopsy showed a white man with moderate jaundice, evidence of muscle wasting of the extremities and severe pitting edema over the ankles. Small brownish-pink petechiae were noted on both legs. Each pleural cavity contained approximately 300 cc. of clear serous fluid. The heart weighed 530 Gm. and was moderately dilated. Both ventricles appeared slightly thickened. The mitral leaflets showed several small, nodular, firm, partially calcified vegetations, and the chordae tendineae of the mitral valve were thickened, shortened and fused. The coronary arteries showed little or no arteriosclerosis and were patent throughout. The lungs were heavier than normal. The left lower lobe showed confluent areas of consolidation. Throughout both lungs numerous small, well circumscribed, blackish-red, firm areas were noted resembling infarcts. The larger arteries were free of thrombi.

The spleen was moderately enlarged and firm. The liver weighed 2600 Gm. and showed a pronounced nutmeg appearance on the cut surface. The gastrointestinal tract appeared grossly normal. Each kidney weighed 250 Gm. They were soft and showed a smooth, yellowish-brown surface. The sex organs were not remarkable. The brain weighed 1250 Gm. and showed moderate atrophy of the white matter with dilatation of the lateral ventricles.

### Microscopic Examination

Microscopic examination of the heart showed marked subendocardial fibrosis involving the chordae tendineae and leaflets of the mitral valve and nodular accumulations of endocardial cells suggesting subendocardial Aschoff bodies. In addition there was a deposition of acidophilic fibrinoid material in the subendocardial layer surrounded by inflammatory cells. The myocardium showed fine interstitial fibrosis and an occasional Aschoff body. The subendocardial conductive muscle fibers showed severe vacuolar degeneration. In summary, the heart presented the picture of old and recent rheumatic heart disease with certain acute changes resembling Libman-Sacks' endocarditis.

Sections through the lung showed severe confluent bronchopneumonia of the left lower lobe. The small blackish-red areas of consolidation proved to be pulmonary infarcts of the acute and subacute type. Many smaller vessels of the lung were occluded by platelet and fibrin thrombi, and the vessel walls showed a pronounced endarteritic reaction with recanalization of the thrombi. In some instances the entire vessel appeared hyalinized. It seems that the patient with the progression of his heart condition developed lesions of pulmonary endarteritis different from those described by Zeek and resembling those found in thrombotic thrombocytopenic purpura. However, the vascular lesions were entirely confined to the lung.

Sections through the spleen showed a marked increase in plasma cells in the pulp. The liver showed marked congestion with centrolobular necrosis which we interpreted as a consequence of his severe congestive heart failure. The liver cells at the periphery of the lobules appeared normal. The bile canaliculi were not obstructed. Sections through the kidney showed moderate toxic degeneration with bile casts in the tubules and interstitial edema. The bone marrow showed definite erythroid hyperplasia. Sections through the peripheral muscle showed necrobiosis of the muscle fibers suggesting the neuropathic type of muscular atrophy. The peripheral nerve fibers showed many foci of severe myelin degeneration. Dr. Liss will discuss the nervous lesions in this patient. Dr. Liss.

Dr. Liss: Sections through the frontal, parietal and insular cortex, the basal ganglia, cerebellum and spinal cord showed widespread general loss of neurons with marked increase of glia. Many of the remaining ganglion cells were distended and contained granules which appeared PAS-positive and appeared smoky gray in Nissl stain. They represent lipochrome substances, which were deposited in abundance. The vessels appeared normal throughout. The entire process was that of a patchy degeneration and not a generalized atrophy. The spinal cord also showed a marked marginal gliosis with swelling of many anterior horn cells containing a similar granular substance. There were numerous amyloid bodies in the white substance of the spinal cord, and there was considerable degeneration of the outgoing nerve fibers. The number of cells in the anterior horn was definitely reduced, but completely normal cells could be found close to the degenerated ones.

This case definitely represents a condition best classified as abiotrophy. To use the proper nomenclature we should call this a corticostriatocerebellospinal degeneration, or Creutzfeldt-Jakob disease.

Dr. von Haam: In summary, I would like to state that this patient suffered from two diseases of chronic nature which progressed side by side. One of them represented a neuropathological condition which involved the central nervous system and the peripheral muscles. The other was progressive rheumatic heart disease complicated by pulmonary vessel thrombosis and vascular endarteritis. The latter may well represent an atypical manifestation of an altered immune biological mechanism of the type considered to be the basis of the group of collagen diseases.

# Maternal Deaths Involving Toxemia

## With Comment of Consulting Obstetrician and Gynecologist

By the OSMA COMMITTEE ON MATERNAL HEALTH

TOXEMIAS still play a significant role in the etiology of maternal deaths, in Ohio. In the 1958 annual report, 13 of the 75 maternal deaths were due to toxemia. Herewith, the Committee presents three cases in this category with *hypertension* the predominant feature. All patients were in the 30 to 39 year age group; all developed hypertension, and died with pulmonary edema; all were voted preventable deaths, based on information available in each case.

### Case No. 286

This patient was a 30 year old white primigravida, who died 24 hours after a classical cesarean section. Her past history was negative. Only meager details are available concerning her prenatal course; prenatal care was reported "adequate." Her attending physician reported that edema, albuminuria and hypertension developed in the 38th week of pregnancy. Treatment is not known. She was not hospitalized until two weeks later, May 24, when her blood pressure was 190/120, the urine showed 4 plus albumin (sole laboratory report), and there was severe edema. With these findings it was reported "but her general condition is good."

Since the patient was at term, and the head well in the pelvis, on the evening of admission she was given castor oil for induction of labor. About 10 hours later hard uterine contractions at three minute intervals started and continued for 12 hours, at which time the cervix was only one finger dilated and she was making no progress. A classical cesarean section was performed, delivering a living baby, weighing 8 lbs. 11 oz. Digitalis was given to support the heart. The type of anesthetic was not stated. One pint of blood was given during surgery, followed by a second pint. Evidence of "congestive heart failure" developed, so an oxygen tent and supportive therapy was instituted. Records report, "The toxemia deepened progressively and the patient never did recover from the congestive heart failure." There was no autopsy.

*Cause of Death (Certificate)*: Toxemia of pregnancy; edema of lungs; cesarean section delivery.

### Comment

The Committee voted this a preventable maternal death. From the scanty information available, members felt that prompt, vigorous treatment of the toxemia was delayed or omitted, both before and after hospitalization. Members also questioned the choice and amount of anesthesia employed for the operation, all of which is left to the reader's imagination.

### Case No. 394

This was a 32 year old white, Para I, cesarean I, who died 17 hours following cesarean section. She had been a bartender, gave a history of bouts of excessive use of alcohol, was treated for syphilis, and was overweight. There were no complications during her first pregnancy and delivery nine years ago.

During this second pregnancy she consulted her physician when in the fourth month of gestation and made a total of 14 office calls. Her last menstrual period was not known. When approximately 39 weeks pregnant her weight was 228 pounds, a gain of 28 pounds. Edema was noted, blood pressure 138/90, urine negative for albumin. Diuril® was prescribed. Five days later there was a slight amount of vaginal bleeding and she was advised to enter the hospital, but refused because she had been enjoying alcoholic beverages. She was in labor about 10 hours before entering the hospital, May 11. Blood pressure 140/100 and 3 plus ankle edema were noted; since she was admitted at 5:30 p. m., no laboratory work was completed. Examination revealed no effacement or dilatation of the cervix. Labor continued and 10 hours later blood pressure was 170/100. The cervix was 9 cm. dilated, but the presenting part was not engaged. She was given 1000 cc. of 5 per cent glucose intravenously and shortly afterward developed acute pulmonary edema. Laboratory studies were not reported. Medical and obstetrical consultation were obtained, and plans were made for immediate cesarean section. Another 1000 cc. of 5 per cent glucose in water was given, rapid digitalization, morphine ¼ gr. intramuscularly, and aminophyllin 7½ gr. was given intravenously. A spinal anesthetic was used for the low cesarean section. A living 11 lb. 3 oz. baby was delivered. She went into shock during surgery. Levophed® was given in intravenous fluids, and other supportive therapy used (rotating tourniquets, two pints blood, oxygen, etc.), but her condition deteriorated progressively and she died approximately 17 hours following surgery. An autopsy was permitted.

*Cause of Death (Certificate):* Acute pulmonary edema — 24 hours; obesity and hypertension; toxemia of pregnancy.

*Pathological Diagnosis:* "Circulatory failure evidenced by marked cardiac dilatation, pulmonary edema, and congestion of spleen and liver." (No protocol or further details of autopsy were available.)

### Comment

The Committee voted this a preventable maternal death, in which (presumably) patient responsibility played a part, — failure to follow physician's orders — obesity and alcoholism. Members asked many questions, of which the following are only a few: (a) Why was delivery by cesarean section not considered much earlier? (b) Why the use of three liters of 5 per cent glucose, which only increased

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

the hydremia? (c) Why was this patient not better prepared, after decision was made to perform a cesarean section? (d) Why was ¼ gr. of morphine used just prior to a cesarean section delivery? (e) Why was a local anesthetic not used in this case?

Members agreed that the patient was a poor "surgical risk," and felt that pulmonary edema probably resulted from hydremia and/or acute fulminating toxemia.

### Case No. 410

This patient was a 39 year old white, Para V, abortus I, who died 15 days postpartum. She was a "known rheumatic fever patient." There was no information concerning her condition during past pregnancies.

She first consulted a doctor when four months pregnant, with last menstrual period October 25. Weight 159 pounds, blood pressure 130/80, urine negative, Rh positive, blood count in normal limits. Physical findings were reported normal. The following two office consultations revealed no change in findings, but on the fourth visit, early in the eighth month of her pregnancy, weight was 182 pounds, blood pressure 180/100, and urine showed 3 plus albumin. She complained of slight headache. Diuril® was prescribed. Seven days later her weight was 177 pounds, blood pressure 170/100, urine showed 3 plus albumin. Apresoline® 100 mg. three times a day was prescribed. A week later, findings were the same, except for a 3 pound weight gain, and the patient stated she felt better. On June 17, seven days later, her weight was 182 pounds, blood pressure 210/120, so she was sent to the hospital for obstetrical consultation and specialized management.

For nine days hypotensive and diuretic therapy was used, including Diuril, Diamox® and Apresoline. Records contain *no laboratory findings*. Blood pressure diminished to 120/76. Membranes were ruptured to induce labor on June 26, and a Pitocin® drip was started in dilution 1/2000. Rapid labor ensued, with normal spontaneous delivery of a 5 pound living infant under epidural block anesthesia. Following delivery, the patient was lethargic, but could be aroused; all reflexes reported normal, blood pressure 208/108. On the fifth postpartum day she went into a deep coma. Intensive therapy was carried out, but the patient died 15 days following delivery. Autopsy was done.

*Pathological Diagnosis:* Cerebral hemorrhage (right parietal lobe and pons); passive congestion of lungs, liver, kidneys, spleen and pituitary gland; basophilic hyperplasia of pituitary gland. (Cardiac findings not described.)

### Comment

The Committee voted this a preventable maternal death. Since she was a known cardiac patient (possibly with chronic hypertension), members believed she should have consulted her physician earlier. They felt that her doctor should have insisted upon hospitalization when the signs of severe toxemia *first* developed. Members agreed that close observation and intensive therapy were delayed, and even after hospitalization there was delay in commencing intensive therapy. Further, members of the Committee felt that termination of the pregnancy should have been considered earlier, and perhaps even by cesarean section, after the toxemia was controlled.

### Comment of Consultant

The following comment of a consultant who is a specialist in obstetrics and gynecology, was furnished at the request of the Committee:

"The Committee has done well in the evaluation of the preceding three cases, especially in light of the scanty and inadequate data available at certain points.

"Case No. 286. Facts in this case are vague in several spots. Either laboratory work (simple or complex) was not done, or if performed it was not recorded — laboratory work is a valuable aid in the diagnosis, prognosis and treatment of toxemias! Obviously the patient was not in a good condition for major surgery — the toxemia should have been treated adequately FIRST!

"Case No. 394. The consultant agrees with the Committee (1) the death *apparently* was preventable and (2) the patient was delinquent and uncooperative. But it also appears that the avoidable factor is *not* unilateral, e. g.: Obviously the large amount of intravenous fluids and blood administered 'overloaded' the already unstabile circulatory system. It would seem that this would have been an excellent case in which to use *hypertonic* glucose intravenously, along with antihypertensive drugs. Further, no mention is made of the use of the present diuretic type drugs.

"Case No. 410. Again I cannot help but agree with the Committee's comments. Certainly the patient should have had a thorough cardiac evaluation earlier! The delay in hospitalization and intensive therapy at the earliest moment is another 'avoidable factor,' indeed.

"In summary, it is desired to point out that early recognition and diagnosis of 'danger signs' plus prompt (adequate) treatment is the keynote to prevention and management of toxemias."

## Maternal Mortality Studies On Local Level Urged

To improve "Maternal Health in Ohio," the primary purpose of the Ohio Maternal Mortality Study is to publish anonymous reports of cases from the files, with comments on diagnosis and treatment. This fulfills one prerequisite of the educational phase.

However, it is urgently desired that a study of maternal deaths be conducted upon each case at a local level where deaths occur. This study may be conducted in conjunction with other scientific medical meetings in the hospitals, societies or small medical groups. An extra copy of the questionnaire form containing the anonymous data on each case may be retained locally for each case study, the original being forwarded to OSMA Headquarters, for the Committee on Maternal Health.

Members of the Committee on Maternal Health represent each of the eleven Councilor Districts of the Ohio State Medical Association. For use in local maternal mortality studies, Chairmen of Committees on Maternal Health of County Medical Societies may obtain additional blank questionnaire forms from respective State Committee Members, or from State Headquarters, 79 East State St., Columbus 15, Ohio.




# NEWS AND Organization Section

# Proceedings of The Council

## Statement Regarding Ohio Medical Indemnity, Inc., for Guidance of Members of House of Delegates Is Adopted

A SPECIAL MEETING of The Council of the Ohio State Medical Association was held Sunday, April 29, at the Headquarters Office, Columbus. The meeting was attended by all members of The Council except Dr. Turner. Others attending were: AMA Delegates Budd, Lincke and Yantes; AMA Alternate-Delegates Robechek, Pease, Martin and Light; Carl W. Koehler, M. D., Cincinnati, Radiologist; Mr. Edward F. Willenborg, Executive Secretary of the Cincinnati Academy of Medicine; staff members, Nelson, Saville, Page, Edgar, Moore and Traphagan.

By official action the minutes of the meeting of The Council held March 17 and 18, 1962, were approved.

### Audit Approved

The annual audit of the books of the Ohio State Medical Association and *The Ohio State Medical Journal* by Lybrand, Ross Bros. & Montgomery, Certified Public Accountants, for the year ending December 31, 1961, was approved by official action.

### Ohio Medical Indemnity

A communication, dated April 13, 1962, from Ohio Medical Indemnity, Inc., submitted at the request of The Council was given prolonged consideration. Certain points in it were explained and amplified by Mr. Charles H. Coghlan, Executive Vice-President of OMI.

Mr. Coghlan also answered many questions not only regarding OMI but about Blue Shield plans throughout the country; how service plans operate; how payment-in-full plans operate; the current OMI 65-and-over program; the various contracts now offered by OMI; the provisions of the proposed national Blue Shield plan for senior citizens, and similar subjects.

At the conclusion of the extensive discussion, The Council adopted the following statement of principles, recommending that President Petznick arrange to have the statement considered at the hearings which will be held at the 1962 Annual Session of the House of Delegates by the Reference Committee on Resolutions to which resolutions referring to Ohio Medical Indemnity will be referred.

1. Ohio Medical Indemnity, Inc., should be authorized to present a payment-in-full indemnity contract, or contracts.

2. The payment-in-full indemnity schedules should be offered on a state-wide basis and formulated with this in mind.

3. Income limits for such contracts should be established.

4. The indemnity schedules and income limits should be formulated by the Ohio State Medical Association in consultation with officials of Ohio Medical Indemnity, Inc.

### Situation in Congress

Reports on the situation in the Congress were presented by Mr. Saville and Mr. Nelson. Mr. Saville also referred to special bulletins and letters

being sent to county society officers and legislative chairmen outlining the necessity for strong action between now and May 20 when the big push for H. R. 4222 will start. There was a discussion also of the so-called Bow Bill and similar measures.

### Polio Immunization

Mr. Page presented a report on the current polio immunization situation in Ohio. He discussed a statement issued April 5 by State Health Director Dwork, a communication dated March 28 from the U. S. Public Health Service, and the statement of policy adopted by the Ohio State Medical Association on September 17, 1961. Councilors were furnished with a tabulation of the polio immunization programs now being carried on in the various counties or planned for the near future. No official action was called for as this data had been presented solely for the information of the members of The Council.

### Care of the Aged

Dr. Robechek presented a report from the Committee on Care of the Aged based on a meeting held on April 11, 1962. By official action Council approved the report of the Committee.

### Cancer Report

A report on behalf of the Cancer Committee was presented by Mr. Edgar based on a meeting held by that committee on April 1, 1962. By official action the report of the committee was approved.

### Special Insurance Committee

A report from the Special Insurance Committee was presented by Mr. Nelson based on a meeting that committee held April 17, 1962. The report indicated that the committee felt that the recent membership poll on insurance matters was inconclusive and that further information should be obtained from the county medical societies and from the various specialty societies. Report of the committee was approved by official action.

### Approve Trumbull County Articles

By official action The Council approved Articles of Incorporation and Code of Regulations adopted by the Trumbull County Medical Society and submitted for official approval.

### 1962 Annual Meeting

There was a report from the Executive Secretary on final arrangements for the 1962 Annual Meeting. Hosts were selected for the various honored guests.

### Re: 1965 Meeting

The Executive Secretary reported that he had been requested by The Council some time ago to investigate the possibility of dates in Columbus for the 1965 Annual Meeting in order that a cycle of having the Annual Meeting in Columbus on each odd numbered year — a legislative year — could be established. Mr. Nelson stated that the Columbus Convention Bureau could make available the week of May 9, 1965, for the OSMA meeting. By official action the Executive Secretary was instructed to secure the week of May 9 for the 1965 Annual Meeting in Columbus and to cancel the dates of April 26 - 30, 1965, in Cincinnati.

It was decided that action would be taken later with respect to the location of the 1966 and 1968 meetings.

The President called to the attention of The Councilors the illness of Dr. Woodhouse, former President of the Ohio AMA Delegation, and to the death of Mrs. Inglis, mother of Dr. Inglis, Councilor of the Tenth District. The Executive Secretary was instructed to express to Dr. Woodhouse the hope of The Council for a speedy and complete recovery and to express sympathy to Dr. Inglis and members of his family on behalf of The Council.

There being no further business The Council adjourned.

Attest: CHARLES S. NELSON,
*Executive Secretary.*

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## Camp Provides Facilities for Diabetic Children

For thirty-three years Camp Ho Mita Koda, located in Newbury, Ohio, has provided camping experience for diabetic children.

Emphasis is on camping fun. The child's specialized needs are met by a full-time staff which includes a resident physician, two graduate nurses, a graduate dietitian on duty at all times and specially trained counsellors.

The first session for the 1962 season begins June 24th and the second session starts July 22nd and ends August 18th.

Details of the current camping program can be obtained by writing the Camp Director, Mr. Lynn Brown, Route 5, Bass Lake Road, Chardon, Ohio, or by contacting the Diabetes Association of Greater Cleveland, 1465 E. 55th Street, Cleveland 3; UTah 1-2000.

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## Rabies Low in Ohio

The year 1961 was the lowest for canine rabies in the state of Ohio, the Ohio Department of Health reported. Of 534 canine heads submitted to the laboratory, six were laboratory positive while two other cases were clinically diagnosed. This is in marked contrast to the 685 canine cases in 1945 and the 214 cases as recently as 1956. No county reported more than one case of canine rabies in 1961.

From all species only 77 cases of rabies were reported in 1961. Of 2,059 heads submitted 74 were found positive. The other three cases were clinically diagnosed by veterinarians with no attempt being made for laboratory confirmation.

# Committee on Eye Care . . .

## Actions Taken Regarding Visually Handicapped Program And Special Examination Where Driver Has Eye Defects

TWO recommendations of major importance were adopted by the Committee on Eye Care at its recent meeting, both receiving subsequent approval by The Council.

Considered by the committee was a communication originating in the Section on Ophthalmology suggesting certain changes as follows in the program for visually handicapped of the State Department of Education:

That the eye examination report should be corrected and revised so that paragraph 1. a. and b. shrould read as follows:

"1. The following should be referred for placement in programs for visually handicapped:

"a. Children having visual acuity of 20/70 or less in the better eye after correction, or who cannot read smaller than 18 point print at approximately 14 inches.

"b. Any child who in the ophthalmologists opinion would benefit by special training or aids."

That since there is every reason to suspect that progressive disease may exist in certain cases of subnormal vision, it is recommended that ophthalmological consultation should be routinely obtained for the benefit of the child.

That in view of the rising costs of visual aids, we suggest that additional funds be appropriated for the purchase of such equipment through the State Department of Education for the children enrolled in this program.

### Informative Data Received

Pertinent information regarding the special education classes for partially seeing children was considered by the Committee during the discussion. It was pointed out:

At present there are in the state, 46.8 units providing special education for partially seeing children, involving 23 school districts and 634 pupils.

The State Board of Education by law has the authority to grant permission to any local board of education to establish and maintain such classes and to establish standards which the local schools must meet to be eligible for state financial aid; also prescribe examinations and tests for determining eligibility for the classes.

The State Board of Education may provide financial assistance to local boards for various kinds of special education units, including units for partially seeing children, depending on the extent of funds appropriated by the State Legislature.

Approximately 83 per cent of the children referred are referred by physicians.

Enrollment is decreasing because of changing concepts in medicine and education regarding the partially seeing child, the present-day theory being that most of them are able to do satisfactory work in regular school classes with some special adjustments and that use of the eyes does not lead to further visual impairment.

### Recommendations Adopted

**After the general discussion, the Committee on Eye Care adopted the following recommendations for consideration by the State Board of Education:**

1. That the eligibility standards for placement and enrollment be modified by eliminating the statement: "Children with 10 or more diopters of myopia who are referred by the examiner."

2. That there be no reference on the front page of the "Eye Examination Report" as to approval of the form by any organization.

### Reasons Stated

Basis for the Committee's recommendation No. 1 was as follows:

When this item was originally incorporated, it was thought that such myopic children would receive more protection from body contact in special classes and thus be less liable to sustain a retinal detachment which is always a threat to high myopias. However, experience has shown that the five hours of protection while in school is offset by the nineteen hours away from school when these children engage in various games and athletics. Originally, the children were placed in special classrooms by themselves. However, this has been changed and the children are now integrated with the normally sighted children. Thus, the reasons for the inclusion of this item no longer exist.

With respect to Recommendation No. 2, it was the belief of the Committee that elimination of any statement of approval by any organization would

prevent embarrassing situations arising from differences between the Department of Education and professional groups over items in the report form. The Committee emphasized, however, that it felt there should be close liaison between the Department and the Committee on Eye Care of the Ohio State Medical Association on such matters and other questions which might arise in connection with the program.

### Why Other Changes Not Approved

It was the sense of the Committee that the following eligibility standard should not be modified: "Children having visual acuity of 20/70 or less in the better eye after correction or who cannot read smaller than 18 point print at any distance." The special committee referred to previously had recommended the addition of the following words, "at approximately 14 inches."

The Committee expressed the opinion that it has been found that some students can read print at a distance of two to six inches from the face without damage to the eyes. For that reason it seemed to be advisable, in the opinion of the Committee, that these students should use their eyes to the best of their ability and not be limited to a 14-inch distance. It was pointed out in the discussion that approximately 83 per cent of the normal child's education is obtained through use of the eyes.

The suggestion in the communication that "any children who in the ophthalmologist's opinion would benefit by special training or aids" should be eligible for admission to the special program was carefully considered. It was the opinion of the Committee that blanket authorization of this kind or insertion of exceptions might open up the program to abuses or extend the scope of the program beyond the letter or intent of the law. The Committee expressed the belief that in unusual cases where substantial evidence is submitted, the child probably would be admitted to the program even though there might not be exact compliance with the written standards.

Also in this connection it was pointed out that inasmuch as these programs are administered locally, each County Medical Society should establish close liaison with the school officials so unusual and exceptional cases can be discussed and considered for admission to the special classes.

The recommendation in the communication that ophthalmological consultation should be routinely obtained for the benefit of the children also was carefully considered by the Committee. The Committee expressed itself as being in favor of the intent of the recommendation that children admitted to special classes for partially seeing children should have the benefit of examinations periodically by an ophthalmologist. However, it was felt that this responsibility would have to be placed on and assumed by the parents of any such child inasmuch as the Ohio law relating to the establishment of special education units in the schools provides only for the maintenance of programs for the education of the child and does not apply to matters involving medical procedures.

With regard to the final recommendation in the communication, the Committee expressed the belief that the question of adequate finances for special education programs should be considered from a local, as well as state, point of view inasmuch as a portion of the funds used are local and controlled by the local Board of Education. Here again, it was pointed out, would be an opportunity for action by the County Medical Society where the need for more funds can be proved. So far as state funds are concerned, the Committee expressed the opinion that this would need additional investigation. The Committee decided to have this question checked immediately prior to the next session of the Ohio General Assembly in January, 1963.

### Driver's License Examinations

A second question considered by the Committee was the matter of eye examinations of persons applying for a driver's license. This question is covered in a series of letters and a resolution of the Columbus Eye, Ear, Nose and Throat Society. The letters included letters directed to Mr. Grant Keys, Director of the Ohio Department of Highway Safety, protesting the use of the School of Optometry clinic at Ohio State University by the State Highway Patrol for examination of the eyes of persons whose eligibility for a driver's license is questioned. Also, included were letters from Mr. Keys to Dr. William H. Havener and to Dr. Edwin H. Artman, President of the Ohio State Medical Association in 1960-61 in which Mr. Keys supported the procedure used by the State Highway Patrol.

### Text of Resolution

The resolution from the Columbus EENT Society read in part as follows:

"It is hereby resolved by the Columbus EENT Society that the attention of the appropriate State officials should be called to the aforementioned facts. The Society recommends that official referrals for further examination of Driver's License applicants with decreased visual acuity apparently uncorrectible with glasses shall be directed to medical physicians specializing in eye care, preferably those certified by the American Board of Ophthalmology."

**After discussion of the question, the Committee went on record in favor of the intent of the resolution of the Columbus EENT Society and authorized the Executive Secretary to send the following recommendations are submitted and, we hope, opinion of the Committee on this problem:**

### Letter to Director

"At a recent meeting of the Committee on Eye Care of the Ohio State Medical Association, the question of eye examinations in relation to the grant-

### Revised Blanks To Be Used For Medicare Claims

Notice of a revision in the forms used for filing claims under the Dependents Medical Care Program has been received from the Dependents' Medical Care, Mutual of Omaha, Box 1298, Omaha 1, Nebraska. This agency is the fiscal administrator for physicians in Ohio.

The DA1863 (white) previously used by both hospitals and physicians for filing claims under the program is being replaced by the revised forms DA1863-1 Hospitals (blue) and DA1863-2 Doctors (buff color).

Both physicians and hospitals have been requested to use the new forms as supplies of the old form are exhausted.

Mutual of Omaha will furnish physicians in Ohio (and certain other states) these forms. Hospitals will send their requests for claims to the fiscal administrator in the state.

ing or revoking of a driver's license was considered. You will recall this subject was discussed in correspondence last April between you and Dr. Artman, then President of the Ohio State Medical Association. As a result of these meetings, the following recommendations are submitted and we hope will receive your favorable action.

"The Registrar of Motor Vehicles should continue the policy, referred to in your letter of April 7, of advising any applicant for a driver's license suspected of having vision defects that might militate against his being granted a license, to consult his personal physician to determine a clarification of the question as to whether or not a driver's license should be issued.

"Where an applicant with decreased visual acuity, apparently uncorrectible with glasses, appeals for reconsideration of action refusing him a license, the Registrar should base his final decision on an examination of the applicant by a physician skilled in diseases of the eye, preferably one certified by the American Board of Ophthalmology, who is qualified to use medicines to perform difficult refractions and examinations and by education, training and experience is competent to detect the presence of diseases involving the eye or causing the eye condition."

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Richville—Dr. Hubert Hansel of Massillon spoke at a recent meeting of the Perry Grange on the proposed King-Anderson Bill.—*Massillon Evening Independent.*

Wilmington—Dr. Irving L. Schwartz, professor and chairman of the department of physiology, University of Cincinnati College of Medicine, recently spoke on the topic, "Science in the Sixties," at Wilmington College.—*Columbus Citizen-Journal.*

# Buckeye News Notes...

Akron—An open debate on "Socialized Medicine" was sponsored recently by the Akron Order of Ahepa. Speaking against socialized medicine were Drs. A. H. Kyriakides and D. G. Retikas.—*Akron Beacon-Journal.*

Canton—Dr. A. R. Furnas of Massillon recently discussed socialized medicine before a dinner meeting of the Navarre Kiwanis Club.—*Canton Repository.*

Carlisle—Drs. Harold McDonald, D. E. Harrison and George Hoke recently participated in a panel discussion on the subject of children's health sponsored by the West Carlisle Parent-Teacher Association.—*Elyria Chronicle-Telegram.*

Cincinnati—The Academy of Medicine of Cincinnati and the Cincinnati Police Department have received awards from Cornell University's Automotive Crash Injury Research group. The Academy and police have completed a two-year survey of automobile accident injuries under the supervision of the Cornell group.—*Cincinnati Enquirer.*

Lebanon—Lt. Col. Stanley C. White, M. D., U. S. Air Force, was awarded the Outstanding Citizen Award at the 11th annual Lebanon Chamber of Commerce awards dinner.—*Dayton Journal Herald.*

Mansfield—Dr. Karl Kuhne, representing the Richland County Medical Society, recently spoke before the Mansfield Lions Club on the topic "Medical Care for the Aged."—*Mansfield News-Journal.*

Massillon—Dr. Frank O. Goodnough, Massillon, was the latest guest speaker at the dinner meeting of the Reedurban-Perry Heights Lions Club. Dr. Goodnough's topic was "The Pros and Cons of Socialized Medicine."—*Massillon Evening Independent.*

New Holland—Dr. Byers W. Shaw, Washingington C. H., explained the stand of the Fayette County Medical Society on proposed legislation which would provide medical care for the aged under Social Security at a recent meeting of the New Holland Parent-Teacher Organization.—*Washington C. H. Record-Herald.*

Portsmouth—An annual spring seminar for physicians was held recently by the Portsmouth Academy of General Practice and the 9th District of the O. A. G. P., with the cooperation of the 9th District of the Ohio State Medical Association. The major speaker was Marjorie Shearon, Ph. D., who spoke on the subject, "Socialism Achieved Through Constitutional Processes."—*Portsmouth Times.*

Ravenna—Dr. Robt. Roy recently addressed the Ravenna Kiwanis Club on the subject, "Medical Care for the Aged." Dr. Fred Bissell, president of the Portage County Medical Society, and Dr. Edward Webb shared the program, answering any questions from the audience.—*Ravenna Record Courier.*

# Ohio Medical Indemnity . . .

## Officers and Directors Elected; Reports on Growth And Financial Condition Made at Annual Meeting

At the recent annual meeting of stockholders of Ohio Medical Indemnity Inc., the Blue Shield Plan in Ohio which is sponsored by the Ohio State Medical Association, the following directors and officers were elected:

**Board of Directors:** Perry R. Ayres, M. D., Columbus; Dwight L. Becker, M. D., Lima; H. M. Clodfelter, M. D., Columbus; Mr. Clair E. Fultz, Columbus; Charles N. Hoyt, M. D., Chillicothe; Msgr. Robert A. Maher, Toledo; Mr. Edgar O. Mansfield, Columbus; Robert S. Martin, M. D., Zanesville; J. Stewart Mathews, M. D., Wyoming; Mr. Stanley R. Mauck, Columbus; Mr. J. A. Meckstroth, Columbus; Mr. Clarence O. Poleni, Cleveland; George L. Sackett, M. D., Cleveland; Mr. John Schoedinger, Columbus; L. Howard Schriver, M. D., Cincinnati, Frank L. Shively, Jr., M. D., Dayton; Mr. Howard W. Slabaugh, Akron; Robert G. Smith, M. D., Circleville; Gordon M. Todd, M. D., Toledo; Edmond K. Yantes, M. D., Wilmington; Starling C. Yinger, M. D., Springfield.

**Officers:** President, Dr. Clodfelter, vice-president, Dr. Yantes, executive vice president, Mr. Charles H. Coghlan, secretary-treasurer, Mr. Charles S. Nelson, assistant secretary-treasurer, Mr. Frank W. Van Holte.

**Executive Committee:** Dr. Yantes, chairman, Dr. Ayres, Dr. Martin, Dr. Sackett, Dr. Shively, Dr. Smith, Dr. Yinger, Mr. Fultz and Mr. Slabaugh.

### Reports Presented

Reports were presented on behalf of the various committees and by the officers. In his report, President Clodfelter made the following comments:

"In reviewing the year's activities, I am impressed with the fact that we were able to remove some barriers to our progress, we were able to develop some new tools to assist us and I believe, we may look forward to the coming year with a better outlook than we did at the beginning of the year."

### Enrollment 2,478,000

The report of Executive Vice President Coghlan covered the following:

The enrollment figures of December 31, 1961, totalled 2,478,000, a gain of 85,890 members but they do not reflect the loss of approximately 150,000 members on January 1, 1962, through the cancellation of General Motors, Ford and Chrysler. Nationally, O.M.I. retains its fourth place position in enrollment, being exceeded only by New York City, Pennsylvania and Michigan. In the year 1961 an intensive campaign to upgrade subscribers from the Standard Contract to the Preferred or Major was started. The year-end report of 1960 indicated that approximately 75 per cent of the contract holders were still enrolled in the Standard Contract, a 4½ per cent improvement over 1959.

As a result of 1961 activity, the number of Standard Contract holders was reduced from 75 per cent to 57 per cent. In the last quarter of '61 groundwork was laid for a campaign during 1962 to inform subscribers, through newspaper advertising and other media, that the Standard Contract is outdated and that their voluntary action is required to upgrade to the more adequate coverage that is available to them.

### Contract Expansion

During the year a new rider to the Preferred and Major Contracts was developed offering coverage for children over 19, but under 23 years of age. Many groups have taken advantage of this coverage, which is offered on the family contract at an additional premium of 5¢ per month.

A new diagnostic rider was finished and is now being offered to groups. This covers diagnostic X-ray, electrocardiograms, electroencephalograms, and basal metabolism readings in a physician's office or in the out-patient department of a hospital. The additional cost for this coverage is 25¢ single and 60¢ family. If a subscriber receives any of these services and the bill is presented by a physician, it is a Blue Shield responsibility.

Continuing progress was made on the development of the Major Medical Contract to be underwritten by Blue Cross and Blue Shield. Because of the different laws under which Blue Cross and Blue Shield operate, many legal and administrative problems were encountered, but most of these have now been surmounted and the contract should be ready early in 1962. This will provide coverages over and above the basic Blue Cross-Blue Shield coverages and will include medical care in the home and office, nursing care, prescription drugs, etc. The patient will pay

the first $100 of his charges above the basic Blue Cross-Blue Shield and will share in the balance on an 80/20 co-insurance basis.

In 1961, the Non-Group Contract, which is sold to individuals "over-the-counter," was amended by increasing the benefits to the level of the Preferred Contract and raising the premium commensurate with this level of benefits.

### Other Developments

The problem of adequate payments under the many O.M.I. contracts became more acute in the year reflecting an increased interest on the part of the medical profession in their Blue Shield Plan.

In the latter part of '61, a Medical Advisory Committee was established in cooperation with the Ohio State Medical Association. This is a large committee of twenty-five members representing practically all segments of medicine, while at the same time incorporating a wide geographical representation. The interest expressed by the members portends great assistance in the solution of medical problems through this committee.

O.M.I. operated through the year with an average staff of 80 persons who received and processed 415,735 claims and paid out $23,257,365. The daily average amounts to 2,100 checks, totaling $91,564.

### Improvement the Goal

Concluding his report, Mr. Coghlan said:

"Our energies have been directed todate to enrollment—we are now shifting to improvement. We have reached millions, but we haven't kept them informed.

"Most of our subscribers are enrolled through their place of employment on a payroll deduction plan, but we can no longer rely solely on the employer to relay our message.

"The lack of knowledge in the hands of our subscriber and our failure to inform him is reflected in his antagonism to his Blue Shield coverage.

"The breadth of contracts now available to the public has made a better informed public. If his contract does not cover anesthesia, chances are he can cite four friends who had a policy that did cover it, and as his desire for protection increases, his willingness to pay additional premium increases.

"The interest of the medical profession also shows a marked increase. Physicians are finding fault with contract provisions and benefits and are offering many suggestions for improvement. Implementation of these suggestions exposes related problems and creates a desire on the part of the profession to find reasonable answers. The neglected pools of resourcefulness and ingenuity have been tapped to supply the ingredients needed to modernize our products. Many of the problems encountered do not relate solely to the insurance phase of the business. There are many medical facets that require research, patience and cooperation."

### Financial Data

The financial picture of Ohio Medical Indemnity was given by Mr. Van Holte, assistant secretary-treasurer. These data appeared in his report:

Assets of $23,449,000, made up largely of cash and government securities.

General Reserve of slightly less than $16,000,000.

Claims utilization resulted in a return 90.6 per cent of premium income to subscribers—an all-time high. With only an 86,000 increase in subscribers in the year 1961, total claims paid increased almost 25,000.

There was a marked increase in claims filed for medical (non-surgical) admissions. Surgical claims increased only 4.3 per cent while medical claims jumped 13.5 per cent over the previous year.

Slightly over 25 per cent of the surgical claims in 1961 can be classified as surgery of the integumentary system. Appendectomies, hemorrhoidectomies and herniotomies showed a marked decrease in incidence and normal deliveries now represent less than 15 per cent of the total of surgical and obstetrical claims paid.

O. M. I. now issues 39 contracts providing different degrees of coverage.

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# New Members . . .

The following are the names of the new members of The Ohio State Medical Association since April 1, 1962. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Clermont**

Albert Van Sickle, Batavia

**Cuyahoga**

Miled Albainy, Cleveland
Hugh D. Bennett, Cleveland
Renate H. Duchesneau, Cleveland
Mary M. Ford, Chagrin Falls
Kenneth V. Harshman, Cleveland
Thomas C. Lloyd, Cleveland
James D. Merida, Cleveland
Kenneth J. Ryan, Cleveland
E. Ray Smith, Cleveland
Robert V. Spurney, Jr., Cleveland
Peter C. Y. Tchen, Chagrin Falls
Ching Yuen Tseng, Cleveland
Willie E. Young, Cleveland

**Franklin**

Judson S. Millhon, Columbus
Frederick H. Shillito, Columbus
Charles G. Wahoff, Columbus

**Fulton**

Maurice M. Galliani, Lyon

**Hamilton**

Patrick A. Clement, Cincinnati
Robert T. P. deTreville, Cincinnati
Alvin Marx Mauer, Cincinnati
Courtney Payne Persinger, Cincinnati

*Continued*

Naomi Green Scandlyn, Cincinnati
John Arthur Williams, Cincinnati

**Lucas**

Anicia Z. Mathews, Toledo
Ian D. Murphy, Toledo

**Mahoning**

Jack Paston, Youngstown

**Marion**

Iwan O. Meyer, Marion
Joseph Myers, Marion
Ursula Nitch, Marion
Norman Williams, Marion

**Montgomery**

David W. Gregg, Dayton
Nicolo Mileti, Dayton
Richard Rabkin, Dayton

**Portage**

Alan Yoho, Kent

**Richland**

Edward Grant Dowds, Shelby
John F. McHugh, Shelby

**Summit**

Herbert Awender, Barberton
Gerald O. Jensen, Akron
Demetrios G. Liakos, Akron
Herbert A. Mahler, Barberton
Joseph B. Pizzino, Akron
Robert B. Tannehill, Akron

# Health Survey in Franklin County . . .

## U. S. Public Health Service Team Will Examine Selected Persons as Part of National Evaluation

FRANKLIN COUNTY, the second Ohio location in the national sample of the Public Health Service's Health Examination Survey, will be visited by the Survey during a three week period beginning August 15. In the summer of 1960 about 150 adult residents of Summit County were examined and now a similar number from Franklin County will be examined.

The examinees will not be volunteers, but persons preselected by a probability sampling technique. In effect, the people to be examined are chosen at random from the whole population of the County — irrespective of their social, economic, or health characteristics.

The examinations will be performed in the Health Survey's mobile examination center, brought to Columbus and set up in a convenient location.

The purpose of the examinations is to collect, on a uniform basis, statistical information on certain chronic conditions, particularly cardiovascular diseases and arthritis, and on physical and physiological measurements. It consists of a medical history; a physical examination for certain conditions for which examination can be made in a uniform way and in a single visit; and for which diagnostic criteria exist; a dental examination; screening tests for visual acuity and hearing; a 12-lead electrocardiogram; blood pressure determinations; 6 foot-14x17 chest x-ray; x-rays of hands and feet; modified glucose tolerance test; microhematocrit determination; serologic test for syphilis; serum cholesterol level; serum bentonite flocculation test; urine sugar (and albumin for males); height and weight; and a series of body measurements which are important — from the standpoint of safety and efficiency — in the design of motor vehicles, aircraft, and farm and industrial machinery.

### Procedure on Findings

Findings are not disclosed to examinees directly. Each individual is asked, however, if he wishes the findings supplied to his own dentist and physician; and if the examinee so authorizes, a report is sent to the physician and dentist he designates.

The health examination is not intended as a screening procedure; referral for diagnosis is not made. The fact that the examination is not complete and is not a substitute for a visit to one's own physician and dentist is stressed with each examinee.

The examining physicians will be fellows or senior residents in internal medicine working temporarily with the Public Health Service. The other team members are nurses, a dentist, x-ray technicians, and history interviewer-receptionists regularly on the PHS staff.

The Health Examination Survey is nationwide and is a major project of the U. S. National Health Survey authorized by Congress in 1956. It constitutes the first attempt in this or any other country to perform examinations on a representative sample of the national population.

### Part of National Picture

The Franklin County "stand" will be the 38th in the National sample. The data gathered in the Survey will not produce separate figures for localities or States. When all the "stands" are completed, the results will yield estimates for the United States as a whole.

Another part of the National Health Survey program — a Health Interview Survey which has been going on since July 1957 — has already produced reports on topics which can be investigated appropriately by this technique. Among the topics published so far are physician visits, dental care, disability, persons injured, acute illnesses, hospitalization, impairments, and broad groupings of chronic conditions.

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## Youngstown Doctor Subs for Annis in Nebraska

When Dr. Edward R. Annis was unable to fulfill a speaking engagement at the opening of the Nebraska State Medical Association, the AMA called on an Ohio physician, Dr. Jack Schreiber of the Mahoning County Medical Society to substitute. Dr. Schreiber is one of the co-organizers of the "Freedom Speakers" team of the Mahoning County Medical Society, a group of 25 physicians who have now given more than 50 talks to service, church, and nursing organizations in Mahoning County. Dr. Schreiber is a veteran of four debates with labor, some of them on radio and television, on the subject of the King-Anderson bill. This was the subject of his keynote address before the Nebraska State Medical Association.

## Clermont County Medical Society Acts To Meet Crisis

Considerable state-wide publicity, as well as favorable editorial comment, have been given to the recent action of the Clermont County Medical Society in assisting the county relief administration to meet its responsibilities despite the lack of funds for relief activities, including medical care. Following is the text of an official statement by the medical society revealing that the members had voted to treat the indigent sick without charge during the financial emergency of the relief administration and to sponsor a fund for hospitalization and drug costs to which voluntary contributions may be made:

"Under date of April 16, a notice signed by Wayne Oney, Director of the Clermont County Department of Welfare, states:

> " 'Effective April 15, 1962, the Clermont County Department of Welfare is forced to discontinue medical care to persons eligible for general relief (GR) and aid to dependent children (ADC) programs, by order of the Clermont County Board of Commissioners, Zenas Anstaett, Charles F. Clark and Charles L. Hook.'

"This situation, we have been told, will continue until January 1, 1963, since the moneys allocated for those two programs for 1962 have been exhausted. On checking with the Clermont County Commissioners and the Clermont County Prosecuting Attorney, Mr. Ralph Hill, we have been told that no other county funds are available to meet this present emergency.

"In view of this emergency, the Clermont County Medical Association, at its regular meeting, held in Milford, Wednesday evening, April 18, voted unanimously that its members treat free, indigent sick duly authorized by the Welfare Department. This is no departure from the care of the indigent ill which they have been giving all along, but recognition of the present crisis within the county and a reaffirmation of the basic tradition of the medical profession to care for the sick whatever the circumstances 'according to my ability and judgment.'

"Realizing that this action alone will not be adequate since the major part of the cost for medical care of the indigent is for hospitalization and drugs (about 80 per cent) the Medical Association sponsored the setting up of a fund for voluntary contributions to be used toward this need. Mr. Flack Douglas has consented to act as chairman of this fund. (Note: Mr. Douglas is a member of the Clermont County Welfare Advisory Board.) The Clermont County Medical Association voted an initial contribution to this fund of $500.00. Another member of the medical profession who does not live in Clermont County contributed an additional $100.00.

"It is recognized that this present crisis is not the responsibility of the medical groups alone, but of the entire community and that there should be a proper channel through which those who have it in their hearts to make a voluntary contribution may do so. Every dollar so contributed will be matched by an equal amount from the State. The Clermont County Medical Association takes note of the fact that, although the State's contribution was originally set up to supplement the funds for such relief raised locally, no such local contribution from the Clermont County Budget has been made for a number of years.

"It was further voted to set up a special committee of the Clermont County Medical Association to review the reasonableness of such bills for hospitalization and drugs before they are paid from this fund. One special instruction to this committee pointed out that the use of expensive preparations of standard drugs when good, inexpensive preparations were available was not a reasonable practice in this situation. Another obligation is to review the validity of the claim of illness where there is good reason to believe the illness did not warrant hospitalization. The members of this committee are Donald K. Ebersold, Chairman; Dr. Floyd E. Owen; and, Dr. Carl Minning."

### Narcotics Registration Must Be Renewed by July 1

On or before July 1, every physician registered under the Harrison Narcotic Act, must (unless he is in military service) re-register with the Director of Internal Revenue of the District in which he maintains an office and pay the Federal Narcotic Tax of $1. Initial application may be made at any time, but existing permits must be renewed on or before July 1, annually.

Registration forms are mailed each year by the Narcotics Division to physicians on record. But the physician is responsible for re-registering whether or not he receives a form. A penalty is incurred by those who fail to re-register before deadline. Gross violations of the Narcotic Act are punishable by heavy fines and imprisonment.

Physicians who administer, dispense or prescribe cannibis must obtain a special permit under the Marihuana Tax Act and pay an additional tax of $1.

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Investigators at the Ohio State University College of Medicine have received a $26,000 grant from the National Institutes of Health to continue an experimental study of destructive processes in the liver due to certain diseases and to overexposure to dangerous chemicals and metallic dusts. The study has been in progress more than two years under the supervision of Dr. Bertram D. Dinman, associate professor of preventive medicine, and Dr. Walter J. Frajola, professor of physiological chemistry.

In Our Opinion

# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*
*— Justice Robert H. Jackson in AAA Supreme Court Case, 1942*

### BIG CHANGE IN AGES OF PATIENTS COMING

According to a study by the Population Reference Bureau, Washington, D. C., the medical profession will have to get ready to care for more aged persons and more youngsters before the end of this decade. In other words the U. S. population is growing younger and older at the same time.

It is predicted that the older population — 65 and over — will reach 20 million and the young group — below age 20 — will total around 87 million.

At present the midwestern and New England states have higher proportions of elderly persons than the mountain states and the South. Ohio's percentage is listed as 9.2 of the state's population.

These are vital statistics which dare not be ignored in our economic, social and health services planning.

### HOLDING JOINT MEETINGS MIGHT BE A BIG HELP

Tip to medical societies and hospitals on how to help physicians curtail the number of meetings they have to attend: The Dade County (Florida) Medical Society has persuaded 12 Miami hospitals to make their general staff and departmental sessions a part of the society's regular monthly meetings. Reports indicate the plan has been successful.

Worth trying, in our opinion, providing, of course, the joint effort doesn't push medical society business — vitally important, these days — into the corner or onto the shelf. There never has been a more important time than now for physicians to gather to discuss social and legislative matters affecting the practice of medicine and health standards.

### WHERE TO GET BADLY-NEEDED HOSPITAL PERSONNEL

Some practical suggestions on how hospitals can acquire adequate personnel to take care of the ever-increasing hospital load have been made by Dr. Robert R. Cadmus, director of Memorial Hospital, Chapel Hill, N. C. He recommends that the following sources be tapped: (1) mature women whose children are grown and who are looking for jobs to occupy their time; (2) men in the fields of nursing and therapy; (3) the handicapped. No doubt many will agree with him that one of the pressing problems in the health field is where to find an adequate supply of nonprofessional hospital service personnel. As Cadmus points out, the job of training such personnel is not that of the hospital but of the high schools and vocational training institutions.

### WARN YOUR FAMILIES ABOUT POISON HAZARDS

Physicians looking after families with small children can be powerful missionaries for poison control activities on the part of parents. Think there isn't a need for plenty of missionary work; that there isn't a need to warn parents how to store things safely in the kitchen and bathroom? If not convinced, digest these figures:

Of the 5602 cases handled by the Poison Control Center at Children's Hospital, Columbus, 37 per cent occurred in the kitchen where bleaches, ammonia, detergents, insecticides, caustics, etc., were carelessly stored and another 33 per cent occurred in the bathroom where medicines were left where small hands could find them.

Next time you're calling on a family with small kids, recite these figures and suggest that they check the situation in their house.

### OHIO IS ONE OF THE SUCKER STATES

According to the UPI, the New Jersey Taxpayers Association in its annual report has debunked the idea that Federal aid to states and local areas is a kind of free lunch that doesn't cost anything. Someone pays the bill and the someones reside in 14 of the 50 states, Ohio being one of the 14.

For every dollar of Federal aid they receive, the 14 sucker states have to put up amounts ranging from $2.01 in Delaware to $1.05 in Florida. Ohio's cost is $1.27 for each dollar received from Uncle Sam. The other suckers are: New York, Connecti-

cut, Pennsylvania, Wisconsin, Maryland, Michigan, Indiana, Massachusetts, Illinois, and California.

The total of Federal aid to states and local communities scheduled for the fiscal year 1963 is $9.9 billion.

Next time someone says: "Let the Federal Government underwrite it; it's our money anyway," tell him the facts of life.

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### CLEVELAND'S MEDICAL CAREER PROJECT

Some 600 members of the Cleveland Academy of Medicine have volunteered to act as advisors to prospective medical students in the Cleveland area for the purpose of assisting them in selecting a medical school and related problems. This is part of the Academy's career's program. In our opinion this is an extremely worthwhile and practical method of interesting more boys and girls in the field of medicine and its allied branches. It could be done in any county. All it takes is some organizing by the County Medical Society.

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### DON'T GET JITTERY; IRS WILL ASSIGN YOU A NUMBER

After January 1, 1963, all who pay Federal income Tax will be assigned a code number by the Internal Revenue Service. If the physician has a Social Security number that will be used; if not, the IRS will assign a code number. Those who do not have a Social Security number should take no action, simply wait until a number has been assigned. This does not apply to the number assigned for payment of withholding tax for employees.

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### HOW TO KEEP PATIENTS FROM GETTING MAD AT YOU

"In the modern practice of medicine, the physician's aide has become highly valuable in reducing or eliminating complaints against the physician-employer," writes Dr. Maurice Greenfeld, Miami, Fla., radiologist, in *New Medical Materia.*

Some of the situations in which the medical aide can be of prime value in preventing trouble for the physician were outlined by Dr. Greenfeld.

For example, he suggests that "the medical aide must keep good billing records and use tactful, sensible collection procedures without resorting to techniques which are harsh, aggressive or harassing." On the matter of reports, he advocates furnishing of reports and X-ray films in cases where this will in no way harm the patient in order to improve patient-relationship.

With respect to appointments, Greenfeld explains the importance of maintaining the doctor's schedule and explaining situations where changes in appointments are absolutely necessary. Obviously, the aide must observe in all respects the principle of confidential communications between doctor and patient.

Dr. Greenfeld's comments on insurance contracts are of special interest. "In most cases," he writes, "the patient has purchased a contract which he only partially understands. When a doctor's services are required, the patient too often assumes he is completely covered. Later, he discovers, to his regret, disappointment, and surprise, that the fee schedule in his contract is not based on any reasonable estimate of his doctor's charges.

"In this case, trouble can be avoided if the medical aide will (1) explain that the policy is a contract between *patient* and insurance company and not between *physician* and insurance company; (2) make sure the physician's fees are outlined in advance where possible, so that the amount not covered by the policy is shown to be the responsibility of the patient to the physician; and (3) point out that, under no circumstances, will either the aide or the doctor falsify an insurance form, despite requests from the patient to do so."

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### LET PUBLIC KNOW ABOUT GRIEVANCE COMMITTEE

Often the question is asked: "Should the existence of a Grievance (or Mediation) Committee be publicized by the County Medical Society?" In our opinion, it should be. The operation of a Grievance Committee is a public relations project of great importance. Unless the public knows about and understands the uses of a Grievance Committee, the public relations impact is lost. Also, those who may believe they have a grievance — real or imaginary —should have a way of knowing how to get their complaint reviewed. Frequently, the opportunity to blow off steam, settles the matter. Be that as it may, not to enlighten the public about this important activity of the County Society is a serious mistake, in our opinion. It just doesn't make sense.

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### HERE'S A LEGAL FORM BOOK YOU SHOULD HAVE

Here's a book every physician should have in his library: "Medicolegal Forms With Legal Analysis." It's a new edition — revised and expanded — of an AMA publication. Physicians and medical students may obtain a copy without charge by writing the AMA, 535 N. Dearborn St., Chicago 10. A charge of $1.00 is made to all others desiring a copy.

The publication contains 49 pages, deals with 18 subjects and provides 47 forms, ranging from letter of withdrawal from a case to authorization to use the eyes of person on whom autopsy is performed.

This is a valuable and helpful publication containing information and advice which will help to keep the physician out of trouble.

# Department of Medicine and Religion . . .

## Director of New AMA Department Explains Purposes at Recent Meeting of OSMA Council

A FORWARD step in coordinating the efforts of the physician and the clergyman has been taken through the creation of the Department of Medicine and Religion of the American Medical Association.

At the March 18 meeting of The Council of the Ohio State Medical Association, the Rev. Dr. Paul B. McCleave, newly appointed director of the Department, explained its purposes and outlined some of the anticipated future activities.

### The Whole Man

"How to provide health care for 'the whole man.' That is the chief concern of our new department." This was Dr. McCleave's nutshell definition of the purpose of the department.

"Too often today," Dr. McCleave says, "we forget to consider 'the whole man.' We forget the patient and parishoner's needs in total health — physical, mental and spiritual. The three are not separable."

Dr. McCleave feels that the best patient care is achieved when physicians and clergymen are able to share mutual concern for the patient and when each contributes his special talents to the problem at hand.

### Ohio Among Pilot States

The new department will foster close physician-clergy relationships through programs carried out on the local medical society level and tailored to fit local needs.

Dr. McCleave is currently working with medical society leaders and physicians in nine states where pilot programs will be launched. He stated that Ohio had been selected as one of these nine states and asked the Council to voice the official cooperation of the Ohio State Medical Association.

By official action, The Council voted to comply with the request that Ohio be a pilot state and offered the full cooperation of the Association to Dr. McCleave and the department.

Ohio will join eight other states; Arizona, Georgia, Iowa, Maryland, Montana, New York, Texas and Utah; in the pilot programs and those which will follow. In these programs, the new department will work through state, county and local medical societies as a servicing and counseling department of the AMA. Specifics of the programs will be determined by local medical societies.

Dr. George W. Petznick, Immediate Past-President of the Ohio State Medical Association, recently accepted an appointment by the AMA Board of Trustees to the AMA Committee on Medicine and Religion.

### Activities Announced

Another project of the new department will be the creation, on the state level, of leadership teams of physicians and clergymen, including psychiatrists and hospital chaplains. Using theoretical case studies, these teams will present programs to various medical and religious gatherings showing how teamwork can be utilized for better patient care.

Dr. McCleave lists two other key functions of his department; the encouragement of closer relations between pastors and physician members of their churches to discuss health and spiritual programs; and the preparation of articles and editorials for the medical and religious press. Early articles will seek to define the patient's total health needs and point up the philosophy of "the whole man."

Dr. McCleave says his department also plans close liaison with hospital chaplains, mental health authorities and pastoral clinical training centers, furnishing any assistance it can. Similar liaison is planned in the area of medical, theological and nursing school curriculums.

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"Diagnostic Countdown," a medical documentary produced by WBNS-TV for Blue Cross and Blue Shield has been selected by the Fifth District of the Advertising Federation of America as the best single program presented by a sponsor during the 1961 television season. "Diagnostic Countdown" told the minute-by-minute story of how the facilities of a modern hospital are employed to save a human life. It was filmed at Riverside Methodist Hospital, Columbus.

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Dr. James L. Kocour, Warren, has been appointed Geauga County health commisisoner.

# Officers and AMA Delegates Elected At the 1962 Annual Meeting

DR. GEORGE J. HAMWI, Columbus, assumed the Presidency of the Ohio State Medical Association at the 1962 Annual Meeting of the Association in Columbus, May 14 - 18, succeeding Dr. George W. Petznick, Cleveland, who will remain on The Council for another year as the Immediate Past-President. Dr. Horatio T. Pease, Wadsworth, was named President-Elect and will succeed to the Presidency at the 1963 Annual Meeting in Cleveland, the week of May 12.

Two new members were elected to The Council. Dr. Robert E. Howard, Cincinnati, was elected Councilor of the First District, to succeed Dr. Charles W. Hoyt, who was not a candidate for re-election. Dr. George J. Schroer, Sidney, was elected Councilor of the Second District, to succeed Dr. Ray M. Turner, Springfield, who resigned.

Members of The Council re-elected to additional terms are: Dr. Floyd M. Elliott, Ada, Third District; Dr. Henry A. Crawford, Cleveland, Fifth District; Dr. Benjamin C. Dieffenbach, Martins Ferry, Seventh District; Dr. Chester H. Allen, Portsmouth, Ninth District; and Dr. Lawrence C. Meredith, Elyria, Eleventh District.

Councilors in the midst of two-year terms are: Dr. Edwin R. Murbach, Archbold, Fourth District; Dr. Robert E. Tschantz, Canton, Sixth District; Dr. Robert C. Beardsley, Zanesville, Eighth District; and Dr. Robert M. Inglis, Columbus, Tenth District. Dr. Philip B. Hardymon, Columbus, is serving a three-year term as Treasurer.

One new Delegate to the American Medical Association and one new Alternate Delegate were elected to fill out the remainder of this year's term and for a two-year term beginning January 1, 1963. Dr. George W. Petznick, Cleveland, was elected a Delegate to succeed Dr. Charles L. Hudson, Cleveland. Dr. Hudson resigned after being named a member of the AMA Board of Trustees. Dr. Harry K. Hines, Cincinnati, was elected Alternate Delegate to the AMA to succeed Dr. Fred W. Dixon, Cleveland, who resigned after many years in that post.

AMA Delegates re-elected for additional two-year terms starting January 1, 1963, are: Dr. Carl A. Lincke, Carrollton; Dr. George A. Woodhouse, Pleasant Hill; and Dr. Edmond K. Yantes, Wilmington. Hold-over Delegates in the midst of two-year terms are: Dr. John H. Budd, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Paul F. Orr, Perrysburg; Dr. Charles A. Sebastian, Cincinnati; and Dr. Edwin H. Artman, Chillicothe.

Alternate Delegates to the AMA re-elected are: Dr. H. T. Pease, Wadsworth; Dr. Robert S. Martin, Zanesville; and Dr. Theodore L. Light, Dayton. Hold-over Alternates are: Dr. P. John Robechek, Cleveland; Dr. Robert E. Tschantz, Canton; Dr. Frederick P. Osgood, Toledo; Dr. J. Robert Hudson, Cincinnati; and Dr. Philip B. Hardymon, Columbus.

Because of the time element, only this brief summary of the election could be included in this issue of *The Journal*. Detailed reports, including minutes of the House of Delegates, will be published in the July issue.

# Pressure on King-Anderson Bill...

## President's All-Out Appeal for Public Support Of H. R. 4222 Gets Quick Answer from Doctors

THE medical profession's determination to preserve the doctor-patient relationship and high quality medical care for the aged, and President Kennedy's all-out drive to rally public support behind the Administration's King-Anderson Bill reached a fever pitch in mid-May.

On the eve of the Administration's giant rally in Madison Square Garden, New York, AMA President Leonard W. Larson, Bismarck, N. D., challenged the use of public funds and the time of public employees in lobbying to promote passage of the King-Anderson Bill.

"How are these rallies organized?," Dr. Larson asked through the public press. "Who is masterminding and coordinating them; who is really behind the National Council of Senior Citizens; where is this organization getting its money; and why isn't it registered as a lobby?"

"Hordes of government employees and officials from numerous executive departments are roaming the country at taxpayers' expense as itinerant salesmen for the King-Anderson Bill," Dr. Larson continued.

### Madison Square Garden Rally

President Kennedy appeared at the Madison Square Garden rally on Sunday evening, May 20, and at the same time was seen on three major television networks, appealing directly to the public for support of the King-Anderson Bill. He appealed directly to doctors of the country, claiming that the American Medical Association is not representing the feeling of physicians in its opposition to the Social Security approach for care of the aged.

In addition to the rally in Madison Square Garden, some 33 other rallies were held throughout the country, four of them in Ohio, (Cleveland, Columbus, Cincinnati, and Youngstown). Three speakers at these Ohio rallies were officials of the federal government, and the fourth was a U. S. Senator.

In Cleveland, Mrs. Esther Peterson, assistant U. S. secretary of labor, was the featured speaker. Agriculture Secretary Orville Freeman was the speaker in Cincinnati. In Columbus, John E. Horne, administrator of the Small Business Administration, spoke at Central High School. The Hon. Vance Hartke, U. S. Senator from Indiana, addressed the rally at Youngstown. Sharing the speakers' platform at the Columbus rally were Hon. Michael V. DiSalle, Governor of Ohio, and Murray D. Lincoln, President, Nationwide Insurance Companies.

Attendance at the 33 national rallies was estimated at 150,000 by the National Council of Senior Citizens. However, based on newspaper reports and information compiled by local officials in the various cities, the actual attendance was less than 45,000.

At a rally in Michigan, where an assistant to the Secretary of Health, Education and Welfare spoke, only eight persons showed up. By actual count, in Charleston, W. Va., only 46 were in attendance in an auditorium that seats 3,500. Several rallies were cancelled.

### AMA Response

The American Medical Association responded quickly to the Administration's nationwide drive. On the following evening, AMA President Larson and Dr. Edward R. Annis, AMA spokesman and chairman of its Speakers Bureau, appeared on a nationwide TV network to present the medical profession's side of the matter. This program, "Your Doctor Reports," was televised in Ohio at 8:00 p. m. Monday evening over WLW-T, Cincinnati; WLW-C, Columbus; WHIZ, Zanesville, and WFMJ, Youngstown. WIMA, Lima, was scheduled to present the program on May 29. Nationally and locally, Dr. Annis and the program were enthusiastically received, and the news media reported his address extensively.

Although the President was granted free time on three major networks, with his speech being classified as a "news event," the American Medical Association was denied this privilege and found it necessary to purchase time on the NBC network for its reply to the President.

In the course of the program, Dr. Annis pointed out that the Kerr-Mills medical aid for the aged law, already passed by Congress, provides means for caring for the elderly who need financial assistance in meeting medical costs. Thirty-eight states already have taken action to implement this law. He further emphasized that more than nine million persons over 65 years of age are protected by some health

insurance, three times more than were covered 10 years ago.

### A Stalemate

At a White House meeting May 1, requested by President Kennedy, seven of the AMA's top officials steadfastly refused the President's efforts to obtain an agreement for a compromise bill. Reliable sources reported the President repeatedly told the AMA officers that the bill was necessary for political expediency.

At the news conference following the meeting, HEW Secretary Ribicoff, who had been in attendance, told reporters that the President expressed his belief that Congress would approve the aged health care bill. To this, Dr. Larson said: "We told him (Mr. Kennedy) in no uncertain terms that we don't believe that. That is not our intelligence. We have a very good line of communication with the grass roots and the support of the old people for the Administration plan is decreasing now that they realize what it will mean to them." Dr. Larson said the propaganda push by the Administration indicates that "it is not getting the support it needs for its bill, and we are convinced the trend is the other way."

### Bureaucrats Lobby

Recent developments have shown an increasing awareness of the publicity tactics being utilized by the Administration to push for H.R. 4222. A move to use Civil Service employees "to explain" Administration proposals was stopped and this incident did not go by unnoticed. On May 2, the Administration was again put on the defensive by a front page article in the *New York Herald Tribune*. The story by Robert C. Toth revealed that "between six and ten government employees have been working—some call it lobbying—in the White House office for more than three months for President Kennedy's plan for medical care for the aged under Social Security." Toth wrote that this group has been writing television and radio scripts, drafting advertisements, and writing publicity releases.

As a result of Toth's story, Pierre Salinger, White House press secretary, was questioned by reporters regarding the "special task force on the medical bill." . . . Salinger denied that the group is a lobbying unit . . . He conceded however that it did supply data on the Administration plan to persons writing to the White House.

As this issue of *The Journal* went to press, H. R. 4222, the King-Anderson Bill, remained in the House Ways and Means Committee, with the possibility that it would be considered in an executive session of the committee sometime late in May or early in June.

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The American Public Health Association's 90th annual meeting will be held in Miami Beach, October 15-19. Registration, exhibits and press headquarters will be in the Hotel Fontainbleau.

## Dr. Hamwi Leads Ohio Fight Against H. R. 4222

In Ohio the response by the medical profession to the King-Anderson challenge is running high. On Tuesday, May 22, Dr. Geo. J. Hamwi, newly installed President of the Ohio State Medical Association, appeared on "Open Mike," popular feature program of radio station WBNS in Columbus and answered questions from the public on the medical profession's opposition to King-Anderson type of legislation. Dr. Hamwi was so enthusiastically received that he was asked to return on May 28.

Dr. Hamwi also issued a statement to the public press on May 21, commenting on President Kennedy's appearance in Madison Square Garden on Sunday, May 20. He said that while the President advocates a Social Security Tax increase to finance a federal health program for the aged, "the medical profession, basing its convictions on statistical, economic, and sociologic evidence, is convinced that already existing government programs plus voluntary prepayment and private health insurance can best meet the needs of our senior citizens."

From clippings coming into the OSMA office, literally hundreds of physicians have joined enthusiastically in this fight. They have appeared almost daily before local organizations and expressed their views on the King-Anderson Bill.

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### Digitalis Study at OSU Continued by Grant

Research workers at the Ohio State University College of Medicine have succeeded in labeling digitalis compounds with radioactive tritium and have opened up a broad study to determine how these drugs produce their beneficial, stimulating effect on the heart.

Dr. Bernard H. Marks, professor of pharmacology, said a three-year study of the distribution, metabolism, and action of various digitalis glycosides will be undertaken under a $59,400 allocation of funds from the National Heart Institute.

Dr. Marks and his associates, including Dr. Saradindu Dutta, a veterinary medical pharmacologist, developed the tritium labeling method in a research project supported during the past three years by the Central Ohio Heart Association. Two compounds studied so far are ouabain and a derivative, dihydro-ouabain, short-acting members of the digitalis group.

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### Useless Equipment Banned

U. S. District Court in Toledo has signed a consent decree permanently banning shipment of seven types of so-called healing equipment manufactured by Electronic Instrument, Inc., Tiffin, makers of radioclast, electron-o-ray and quto-electronic instrument, on the grounds that the Food and Drug Administration has described them as "expensive but useless machines."

# Ribicoff's Smoke Screen

"Welfare Secretary Ribicoff calls it 'blackmail' when a group of New Jersey doctors declare they will not treat patients under terms of the King-Anderson bill being pushed by the administration, a plan which would raise taxes for everybody to pay for certain items of medical care of the aged under Social Security. Furthermore, he asserts carelessly the doctors are in violation of their Hippocratic oath and repeats his old complaint that doctors have no right to even talk about this proposed legislation since they aren't going to be paid under its rules.

"Ribicoff is so far off base he isn't even in the ball park. In the first place, it is dictatorial nonsense to tell any group or individual not to be concerned about any federal tax legislation. Secondly, the New Jersey doctors pledged to continue their practice of treating, without charge, indigent patients of any age. Almost all doctors donate part of their time schedules this way in co-operation with hospitals and out-patient clinics.

"As citizens and taxpayers the doctors have the right to oppose or approve any proposed measures. Ribicoff, however, conveniently screens the fact that under the King-Anderson bill his own department would pass on applications of hospitals and nursing homes to participate; that he alone would set prices and fees; that participation would be voluntary to begin with; that nobody has the slightest notion what the plan would cost or how many institutions would enroll under it. Finally he tries to overlook the Kerr-Mills law already in force in more than half the states under which federal aid is granted states to aid their actually needy old folks. The law is comparatively new and hasn't had time for fair testing. It also has been turned down in many states where the Democratic Party-controlled leadership hopes this non-cooperation will result in passage of the more spectacular King-Anderson measure.

"It is becoming more and more apparent that the proposal to tie in the health measure with Social Security is losing ground as people, while cognizant of the need, see more value in other long range plans which don't involve more red tape and federal control. Ribicoff's blackmail charge is a contemptible slur." — *Cleveland Plain Dealer,* May 7, 1962.

## Two Western Reserve Researchers Receive PHS Career Awards

First two Western Reserve University doctors to win Research Career Awards of the U. S. Public Service are Dr. Robert M. Berne, acting head, Department of Physiology, School of Medicine, and Dr. John W. Harris of Metropolitan General Hospital.

Each will receive full support from the National Institutes of Health for his entire professional career, subject to review every five years. The awards are for experienced investigators who are continuing to develop in productive careers of independent research and teaching in the medical sciences.

Dr. Berne's research deals with physiological and biochemical aspects of cardiac function and is an outgrowth of his studies under grants by the Cleveland Area Heart Society on the mechanism regulating coronary blood flow.

Dr. Harris, a hematologist, has been engaged in research on the mechanisms of red cell destruction and metabolic abnormalities.

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Physicians interested in certification by the American Board of Obstetrics and Gynecology should contact the executive secretary and treasurer before July 1 of this year. Communications should be addressed to Robert L. Faulkner, M. D., 2105 Adelbert Road, Cleveland 6, Ohio.

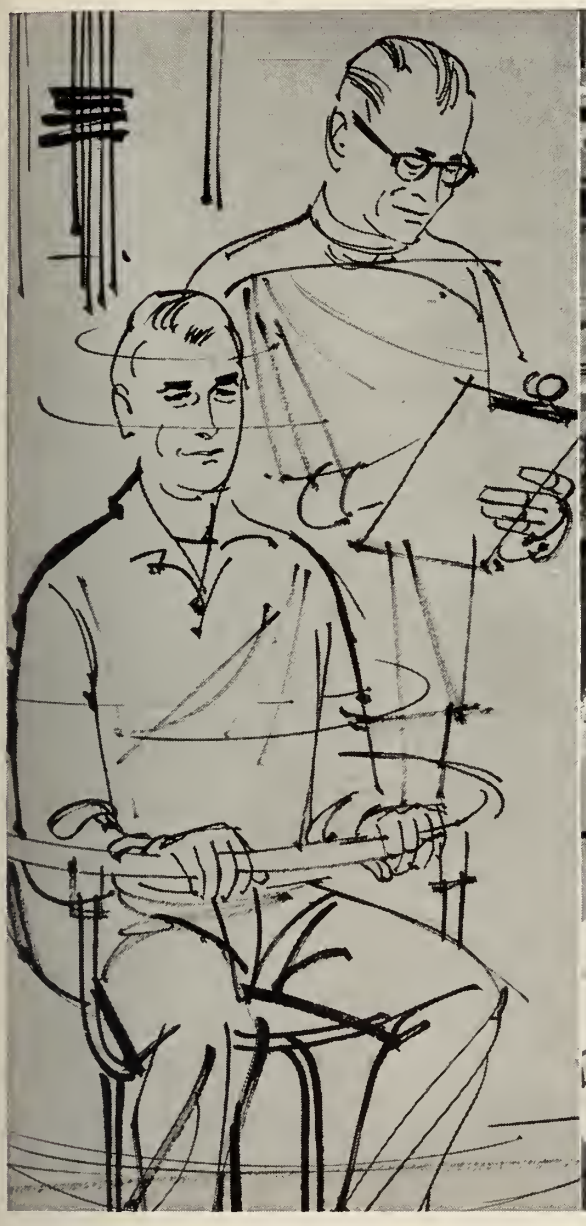
## Duplicate Works Needed to Replace Losses by Library Fire

The research library of the Institute of Experimental Medicine and Surgery of the University of Montreal has suffered extensive loss by fire. Attempts are being made to replace the loss and a special appeal has been made for works dealing with endocrinology and stress. Communications should be addressed to Dr. Hans Selye, Professor and Director, Institute of Experimental Medicine and Surgery, University of Montreal, P. O. Box 6128, Montreal 26, Canada. Also the permanent mailing list of the library has been destroyed and persons who wish to have their names reinstated should write to the foregoing address.

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## USAN, Term To Designate Generic Drug Names

"United States Adopted Names" — USAN — will be the new term applied to nonproprietary names of drugs by the recently formed Drug Nomeclature Committee of the American Medical Association and the United States Pharmacopeia. Primary objective of the new committee is to find a single, suitable, nonproprietary name for each drug in general use. The term, "USAN" does not mean that the names are adopted by or have specific sanction from the federal government.



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Research in the Service of Medicine

# Do You Know? . . .

Dr. Leonard W. Larson, president of the American Medical Association, Dr. Albert Sabin, developer of the Sabin live polio vaccine, and Dr. Thomas E. Shaffer of Columbus were the featured speakers at a recent meeting of the American Association for Health, Physical Education and Recreation held in Cincinnati.

* * *

Edgar O. Mansfield, administrator of Riverside Methodist Hospital, Columbus, is the newly elected president of the Ohio Hospital Association. He succeeds Harold A. Zealley, administrator of Elyria Memorial Hospital.

* * *

Dr. J. Martin Byers, of Greenfield, has been elected president of the Highland County Board of Health.

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Dr. Patrick Hughes, Port Clinton, has been re-elected to the Ohio Information Committee's 50-member Board of Trustees. The O. I. C. is a non-partisan political action committee with 2,000 members in 84 Ohio counties.

* * *

Governor DiSalle has renamed Dr. Donald F. Bowers, Columbus, to the state medical board for term ending March 18, 1969.

Dr. Mary Agna, Yellow Springs, has been named Clark County health director.

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At the annual meeting of Cleveland Medical Library Association, Dr. Charles L. Hudson was installed president, succeeding Dr. Webb Chamberlain, Jr. Dr. David A. Chambers was elected vice-president and president-elect, and Dr. Amasa Ford, secretary-treasurer. Dr. Ruth R. Rauschkolb and Dr. William L. Huffman were elected new trustees. Dr. Philip F. Partington was re-elected a trustee.

* * *

The American Cancer Society has awarded a $35,000 Institutional Research Grant to Ohio State University for 1962 to encourage the investigation of new and venturesome ideas in cancer research. Some 11 investigators are designated to direct various phases of the project.

* * *

Dr. Lewis H. Urling, Jr., Lancaster, has been re-elected to the Ohio Information Committee's 50 member board of trustees.

* * *

A 26-page section of the April 22 *Sunday Herald-Leader,* Lexington, Ky., was devoted to the new University of Kentucky Medical Center.




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**IMPOTENCE**
*is indicated*
**ANDROID**T.M. tablets
ANDROGEN-THYROID-COMBINATION

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| Thiamine HCl .....10 mg. | Thiamine HCl .....10 mg. |

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AVERAGE DOSE: One tablet three times daily.
AVAILABLE: Bottles of 100 and 500 at your pharmacy.
CAUTION: Not to be used when testosterone is contra-indicated. Federal law prohibits dispensing without prescription.

1. *Methyltestosterone-Thyroid in Treating Impotence,* A. S. Titeff, *General Practice, Vol. 25, No. 2, February, 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations,* L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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**SPOKANE, WASHINGTON**
Saturday, June 2, 1962
The Davenport Hotel

**BIRMINGHAM, ALABAMA**
Saturday, June 2, 1962
Dinkler-Tutwiler Hotel

**WASHINGTON, D. C.**
Saturday, June 9, 1962
Marriott Motor Hotel

**LAND O'LAKES, WISCONSIN**
Sunday, June 17, 1962
King's Gateway Hotel and Inn

**EAU CLAIRE, WISCONSIN**
Wednesday, June 20, 1962
The Eau Claire Hotel

**ATLANTA, GEORGIA**
Wednesday, July 18, 1962
The Hotel Dinkler Plaza

**SAN ANTONIO, TEXAS**
Sunday, September 9, 1962
The Granada Hotel

**CLARKSBURG, WEST VIRGINIA**
Sunday, September 9, 1962
The Stonewall-Jackson Hotel

**TYLER, TEXAS**
Wednesday, September 12, 1962
Carlton Hotel

**KANSAS CITY, KANSAS**
Friday, September 14, 1962
Battenfeld Auditorium

**WOODSTOCK, VERMONT**
Wednesday, September 19, 1962
The Woodstock Inn

**NIAGARA FALLS, ONTARIO**
Saturday, September 29, 1962
Sheraton-Brock Hotel

**RAPID CITY, SOUTH DAKOTA**
Saturday, October 6, 1962
Holiday Inn

**FINDLAY, OHIO**
Thursday, October 11, 1962
The Findlay Country Club

**HONOLULU, HAWAII**
Sunday, October 21, 1962
The Princess Kaiulani Hotel

**NEWARK, NEW JERSEY**
Sunday, October 28, 1962
Robert Treat Hotel

**SANTA BARBARA, CALIFORNIA**
Saturday, November 3, 1962
Santa Barbara Biltmore Hotel

**INDIANAPOLIS, INDIANA**
Wednesday, November 7, 1962
Marott Hotel

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## AMA Annual Session in Chicago Offers Many Features

Attention is again called to the 1962 Annual Session of the American Medical Association in Chicago, June 24-28. For the first time the convention will be held in Chicago's new exposition center offering every conceivable convenience and bringing exhibits and scientific program features into one area.

Here are features that every physician will want to consider:

- All scientific features in one building, a cross-section of every medical interest.
- More than 200 eminent scientists in the Multiple Disciplinary Research Forum.
- Eight general programs by combined specialties scheduled for the first time.
- More than 700 exhibits staffed by top researchers and expert technologists.
- Surgical innovations and symposia on live color TV and motion picture premieres.
- Special daily features representing each medical discipline — and countless other vital programs of practical value in practice.

Doctors who attend the meeting will have an opportunity to study nearly 400 scientific exhibits of all kinds. Furthermore, they will have a choice of hearing lectures on the scientific program in which more than 2,400 physicians will participate.

### How To Make Reservations

The entire program of the AMA Annual Meeting was published in the May 19 issue of the *Journal of the AMA.*

Registration in advance may be made by clipping one of the coupons entitled "For Advance Registration of Physicians," and mailing it to the address indicated: Circulation and Records Dept., American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois.

Hotel room reservations also may be made through the coupon appearing in the *Journal of the AMA.* After it is filled out it should be mailed to the Chicago Convention Bureau, Suite 900, 134 North LaSalle St., Chicago 2, Illinois.

### Many Ohioans Participate

Ohio's official delegation of nine delegates and their alternates will attend the meeting and be present at sessions of the House of Delegates. Many Ohio physicians also are participating in various features of the program. The Woman's Auxiliary to the AMA is meeting in Chicago the same week as the AMA session and will provide many interesting features for the ladies.

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## OSMA Staff Member Participates In Radio Panel on H. R. 4222

On April 29, Charles W. Edgar, Jr., Administrative Assistant for the Ohio State Medical Association and Secretary of its Rural Health Committee, appeared on the "When Neighbors Meet" program of radio station WRFD. On the program, he participated in a 30-minute panel discussion, presenting the medical profession's viewpoint on the King-Anderson Bill. Other persons on the panel were from the Nationwide Insurance Companies, the Farm Bureau Federation and the Social Security Administration.

On May 28, Mr. Edgar appeared before the Public Affairs Committee of the Columbus Area Junior Chamber of Commerce. He presented arguments in opposition to the King-Anderson Bill, while Frank Brockmeyer representing the Ohio AFL-CIO and the National Council of Senior Citizens, presented arguments for the Bill.

---

## Chronic Respiratory Diseases

Combined mortality from chronic respiratory diseases — namely, chronic bronchitis, the chronic pneumonias, bronchiectasis and emphysema — rose fairly steadily from about 5 per 100,000 population in 1949 to 10 per 100,000 in 1959. The rise in mortality was particularly rapid among males. — *Metropolitan Life.*


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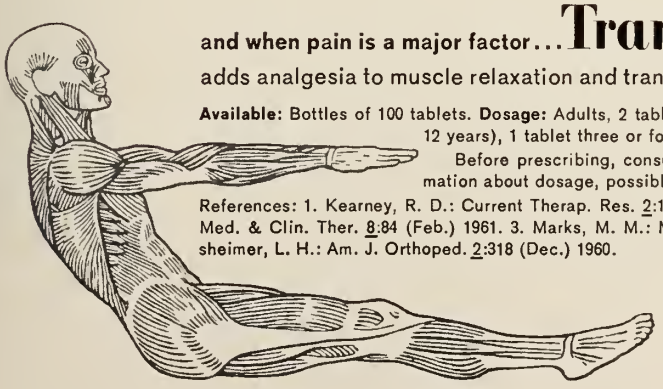
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These two complementary actions of Trancopal are commented on in many recent reports; e.g., Kearney[1] states: "...Trancopal has proven to be an extremely effective striated muscle relaxant and subcortical tranquilizer." Cornbleet,[2] discussing the use of Trancopal in dermatologic practice, comments: "Noteworthy was the soothing effect of chlormezanone without interference with normal activities or alertness... Patients were found more tractable and easier to control."

Marks[3] found that in patients with backache "...Trancopal offered considerable relief by alleviating both apprehension as well as musculoskeletal discomfort." Hergesheimer[4] comments: "...Trancopal acts to reduce the initial painful spasm and to allay anxiety, resulting in a cooperative patient whose subsequent recovery and return to work is accomplished more quickly."

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Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. Kearney, R. D.: Current Therap. Res. 2:127 (April) 1960. 2. Cornbleet, T.: Antibiotic Med. & Clin. Ther. 8:84 (Feb.) 1961. 3. Marks, M. M.: Missouri Med. 58:1037 (Oct.) 1961. 4. Hergesheimer, L. H.: Am. J. Orthoped. 2:318 (Dec.) 1960.

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# Workmen's Compensation . . .

## Third Article in Series Tells of Evidence Necessary in Occupational Disease Claims

THIS is the third in a series of articles on Workmen's Compensation being published by *The Journal*. It covers the subject of occupational disease claims. The previous two articles, published in the April and May issues, related to claim forms and medical fee bills. All of the articles were prepared with the assistance of members of the administrative staff of the Bureau of Workmen's Compensation.

An occupational disease is a disability peculiar to a particular industrial process, trade or occupation and refers to a risk or exposure to which an employee is not ordinarily subjected or exposed to outside of or away from his employment. In contrast to an injury, an occupational disease results from repeated trauma or exposure while an injury is the result of one specific traumatic incident.

The payment of medical fee bills in certain types of occupational disease claims is often delayed because of the failure of the attending physician to include sufficient medical proof of the claimant's disability or the failure by the attending physician to show a medical relationship between the claimant's disability and his employment.

The physician can expedite the allowance of the occupational disease claim by providing all the necessary medical evidence in the initial claim application.

### Common Problems

The following review will discuss some of the more common evidentiary problems and should aid the attending physician in the completion of his initial medical report and diagnosis.

### I. Metal and Chemical Intoxication and/or Poisoning

A. Proof of Contact

There must be proof in the claim file that the claimant had an opportunity for contact with the alleged metal, chemical, or gas irritant in the performance of his job duties.

B. The Extent of Contact

There must be sufficient information as to the length and extent of the alleged contact or exposure to medically substantiate the relationship between the claimant's disability and his employment.

C. Medical Basis For Diagnosis of Claimant's Disability As An Occupational Disease

The pathology and symptomatology used in the diagnosis of the claimant's disability as an occupational disease should be included in the attending physician's report. The results of any tests performed on the claimant should be included in the report with specific emphasis upon the quantitative findings of the tests and the name of the laboratory performing these tests.

*Example* — Basophilic stippling of the RBC without a report of the quantitative determination of the lead content of the urine and/or blood will not be accepted as pathognomonic of lead intoxication.

### II. Dermatitis and Skin Allergies

A. What industrial irritant or sensitizer caused the skin condition of the claimant, and how did the contact or exposure occur?

B. What tests were used to determine the claimant's allergy to a particular substance and what were the results of these tests?

C. If the area of irritation is not one of maximum exposure, the attending physician should include an explanation of this with his medical diagnosis.

### III. Repetitive Movement Disabilities

A. The disability must be due solely to the repetitive movements performed by the claimant. The

**Want A Speaker on Subject of Workmen's Compensation?**

The Bureau of Workmen's Compensation and the Industrial Commission of Ohio will be happy to provide a speaker on Workmen's Compensation, with special emphasis on fee bills, claims procedure and related subjects. Requests should be directed to: Mr. George H. Thompson, Chief Deputy Administrator, Claims Section, Bureau of Workmen's Compensation, Columbus 15, Ohio.

aggravation of a pre-existing injury or condition by the repetitive movement performed is not considered a compensable occupational disease.

B. There must be a medical relationship established between the claimant's disability and the repetitive movements that he performs. This relationship should include the amount of exertion required in the alleged movement and the number of such movements performed per hour and per day.

### IV. Nervous Disorders From Routine Job Duties

Any type of work has routine duties and daily stress and strain. For these reasons it is unusual to consider that nervous disorders are peculiar to a particular industrial process, trade, or occupation and to which an employee is not ordinarily subjected or exposed outside or away from his employment.

## New AMA Book To Be Published On Medical Terminology

The American Medical Association is scheduled to publish in June the first edition of a paperback, pocket-size guide to the preferred medical terms of all important diseases. Entitled *Current Medical Terminology,* the handbook will provide a definition of each disease indicating the known or possible causes and the most characteristic disturbances and findings.

The first issue will eliminate duplication and outdated terms and will contain less than 500 pages and sell for $2. It will list alphabetically 4,000 diseases and conditions and give definitions. Revised editions are anticipated every 12 or 18 months. A computer system was used in developing the handbook and will also be used to keep a running check on accuracy for future editions.

*Current Medical Terminology* is not regarded as a replacement for *Standard Nomenclature of Diseases and Operations (SNDO),* but rather a companion to the larger book.

Dr. Herbert W. Salter, Cleveland, is the new vice-president of the American Academy of General Practice.

## What To Write For

**Environmental Health Problems.** Report prepared by an advisory committee of 18 top level scientists under the chairmanship of Dr. Paul Gross, president of the American Association for the Advancement of Science. Includes seven major recommendations for action to safeguard the environment against chemical, radiological and other pollutants of air, land, water, and food. ($1.00) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C. (HEW Publication No. 908.)

* * *

**Diabetes Fact Book.** Provides statistical data relating to diabetes — its incidence and prevalence, disability from it, mortality and life expectancy, epidemiologic factors, casefinding activities, and facilities, services, costs, and rehabilitation. (30 cents.) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C. (Catalog No. FS 2.2:D54/9.)

* * *

**Illegitimacy And Its Impact On The Aid To Dependent Children Program.** Presents information relating to illegitimacy and its relation to the growing population; causes of illegitimacy; community resources available to the unmarried mother and her child; factors underlying the increase in the aid to dependent children caseload; illegitimate children receiving aid to dependent children; and State action reflecting concern about illegitimacy. 1960. (35 cents) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C. (Catalog No. FS 3.2:I16.)

* * *

**What You Should Know About Two-Way Radio.** Pamphlet explains initial costs of installing a basic communications system and provides information on the preliminary steps required in filing for an FCC license. Write Section P, General Electric Communication Products Department, Box 4197, Lynchburg, Virginia.


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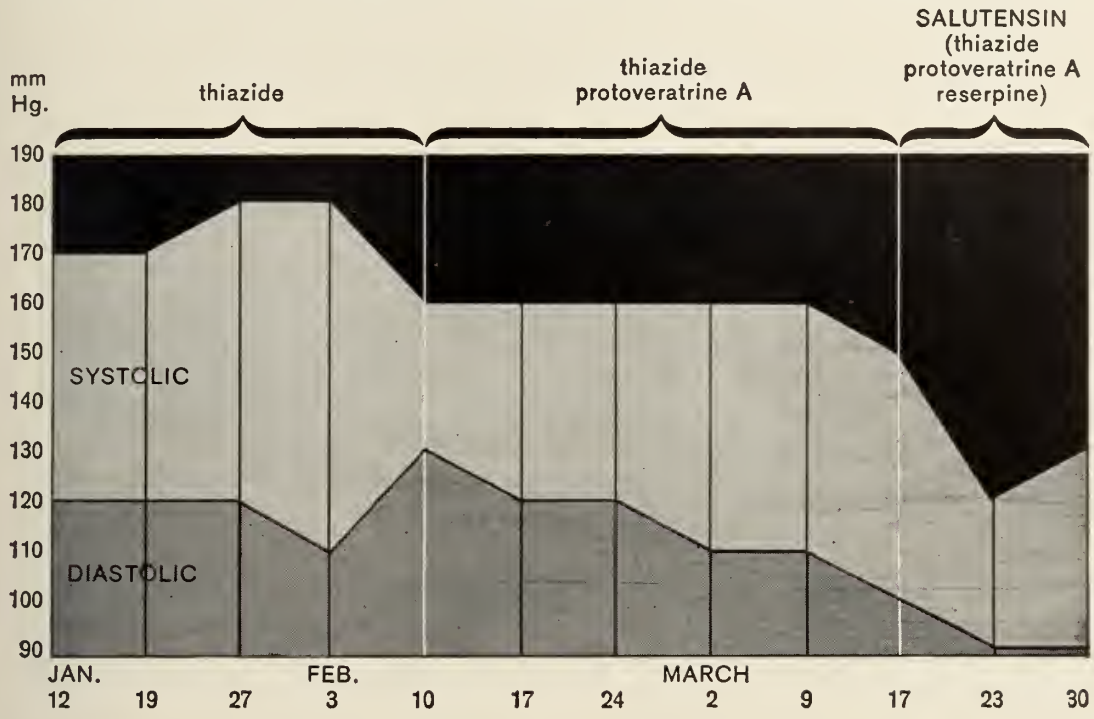
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**References:** 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.


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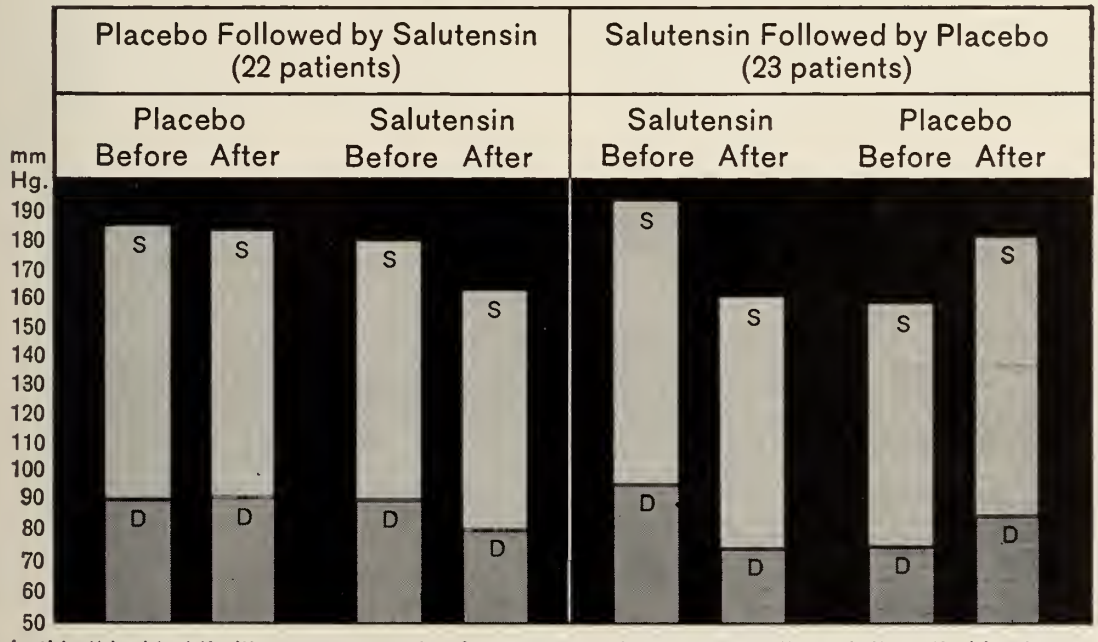
**11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE**

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)




**3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY**

Mean Blood Pressures–Systolic (S) and Diastolic (D)




In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

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# Activities of County Societies...

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### ADAMS

The Adams County Medical Society met for luncheon at the Adams County Hospital on May 13 and heard a discussion on "Cervical Syndromes" by Dr. Bert McBride.

### BUTLER

Dr. John F. Mueller, Cincinnati, spoke before the April 25 meeting of the Butler County Medical Society at the Manchester Motor Inn, Middletown. His talk, entitled "A Doctor Visits Burma," covered experiences on a medical survey sponsored by the National Institute of Health, the Defense Department and the State Department. A native of Butler County, Dr. Mueller is now associate professor of medicine at the University of Cincinnati.

### CLINTON

Dr. Arthur Evans of Cincinnati was guest speaker at the Clinton County Medical Society luncheon meeting at Don McNeil's Restaurant, Wilmington, April 3. He talked on urinary infections.

The group celebrated the coming birthday of Dr. Robert Conard with a birthday cake.

Dr. Edmond K. Yantes, head of the Mental Health Association, reported on the progress made towards a child guidance center. He said it is hoped to get part time services from the senior clinic. The society approved any efforts made towards establishing such a clinic.—*Wilmington News.*

### HAMILTON

Two joint meetings with other organizations highlighted the program of the Academy of Medicine of Cincinnati in April.

Dr. Leonard W. Larson, President of the American Medical Association, was featured on the program April 3 for a joint meeting with the Cincinnati Dental Society, the Hamilton County Pharmaceutical Association and the Cincinnati Veterinary Medicine Association. His subject was "Reason Must Prevail."

The Cincinnati Society of Internal Medicine cosponsored a program on April 17. Guest speaker was Dr. Gordon Meiklejohn, professor and director of the Department of Internal Medicine, University of Colorado College of Medicine. His subject was "The Respiratory Viruses."

## Second District

(COUNCILOR: GEORGE J. SCHROER, M. D., SIDNEY)

### CLARK

Dr. William E. Abbott, associate professor of surgery at Western Reserve University School of Medicine, spoke on "Fluid Electrolyte and Nutritional Alterations in Gastrointestinal Disorders," at the April 16 meeting of the Clark County Medical Society in the Hotel Shawnee, Springfield.

### MIAMI

A meeting of the Miami County Medical Society was held at the Troy Country Club in May with dinner and a program. Speaker was Dr. Joseph R. McWhirt, Dayton, whose subject was "Maxillofacial Injuries."

### MONTGOMERY

Dr. George J. Hamwi, Columbus, professor of medicine at Ohio State University, and 1962-1963 President of the OSMA, was guest speaker at the




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Fourteen patients, age 66 to 77, treated with Winstrol, usually in a dosage of 6 mg. daily, for various periods in order to correct underweight, weakness and chronic fatigue. Marked improvement occurred in appetite, sense of well-being and strength; almost all patients gained weight.

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Twenty-one patients with arthritis treated with Winstrol for pain and limited mobility due to osteoporosis. With few exceptions, dosage was 6 mg. daily; duration of treatment varied from a few weeks to 6 months. In 8 patients relief of symptoms was excellent and in 6 moderate. Of the 7 persons in whom no relief was obtained, 5 had received treatment for less than one month and some had been given doses below 6 mg.

...for patients with malignant disease—
NOTABLE WEIGHT GAINS, INCREASED APPETITE AND SENSE OF WELL-BEING

Twenty-six patients, mostly women, weak, emaciated and seriously ill, were administered Winstrol in dosage of 6 mg. daily for periods extending up to 14 months (average 6.7 months). Notable weight gains occurred. Patients showed increased appetite, alertness and confidence, better appearance, increased mobility and tolerance to pain.

...for patients with chronic, non-malignant disorders—
IMPROVEMENT IN WEIGHT AND GENERAL ACTIVITY, INCREASED SENSE OF WELL-BEING

Eight patients with advanced tuberculosis, bronchopulmonary disease, nephritis and ulcerative colitis treated with 6 mg. of Winstrol daily for from 3 to 4 months. Gains in weight varied from 6 to 27 pounds with increased sense of well-being and improvement in general activity.

...for undernourished, underweight children and adolescents—
NOTABLE IMPROVEMENT IN APPETITE AND OUTLOOK, MARKED INCREASE IN WEIGHT AND HEIGHT

One hundred and twenty children, age 1 to 11 years, underweight and in poor health, were given Winstrol for several months. Majority received daily dosage of from 2 to 4 mg. In nearly all, appetite was improved. Over 70 per cent showed significant gains in weight of from 5 to 17 pounds.

DOSAGE: Usual adult dose, one 2 mg. tablet t.i.d. just before or with meals; children from 6 to 12 years, up to 1 tablet t.i.d.; children under 6 years, ½ tablet b.i.d. Available in bottles of 100 tablets.

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April 6 meeting of the Montgomery County Medical Society in the Van Cleve Hotel, Dayton. His subject was "Etiology of Diabetes."

## Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

### ALLEN

Dr. Nichols Vorys, assistant professor of obstetrics and gynecology, Ohio State University, spoke at the April 17 meeting of the Lima and Allen County Academy of Medicine. His subject was hormone therapy. The dinner meeting was at the Shawnee Country Club.

### MARION

Marion's physicians, dentists and lawyers heard a panel discussion on workmen's compensation plans Tuesday night (April 3) at the fourth annual medical-legal-dental meeting at Hotel Harding.

Dr. Jay Plymale was moderator. Panelists were Dr. Dan Murphy, Paul D. Michel, Daniel LaMarche, John Fontana, Columbus attorney, John Lewis, Columbus actuary, and Edgar Weaver of Mansfield, Ohio Industrial Commission claims examiner.

Dr. Frank Murphy, president of the Marion Academy of Medicine, conducted the session. Welcomes were extended by Robert O. Stout, Marion County Bar Association president, and Dr. Robert W. Imbody, president of the Marion Dental Academy .— *Marion Star.*

### SENECA

Treatment of eye conditions with the Meyer-Swicheroth light was explained by Dr. William H. Havener, professor of ophthalmology at Ohio State University, before the Seneca County Medical Society. The dinner meeting was held in the Elks Club, Fostoria, April 17.

## Fourth District

(COUNCILOR: EDWIN R. MURBACH, M. D., ARCHBOLD)

### LUCAS

The Academy of Medicine of Toledo and Lucas County on April 6 honored 16 resident doctors from five hospitals for their work in independent research.

Working on their own time and without subsidies, the residents prepared papers which were evaluated by a committee of Academy members. Six of the papers were read before members of the Academy.

Top winner was Dr. Otilla M. Yetis, and second prize winner was Dr. Hubert C. White. Others selected to read their papers were Dr. Harry Mil-




ler, Dr. E. John Fales, Dr. Wolfgang P. Hartz and Dr. Robert Collins.

## Fifth District

(COUNCILOR: HENRY A. CRAWFORD, M. D., CLEVELAND)

### CUYAHOGA

Don Dunham, medical writer for the *Cleveland Press,* devoted part of four columns for an illustrated report of the April 25 program cosponsored by the Academy of Medicine of Cleveland and the Cleveland Area Heart Society. The article begins as follows:

For the first time, 11 prominent heart surgeons, the men who have built this city's great reputation in heart surgery were on the same platform to discuss advances in their field and its problems. . . .

They were Drs. Earle B. Kay, St. Vincent Charity Hospital; Frederick S. Cross, St. Luke Hospital; George H. A. Clowes Jr., Metropolitan General; Donald B. Effler, Cleveland Clinic, discussing surgery in rheumatic heart disease.

Drs. Claude S. Beck, David S. Leighninger, his associate, both of University, and Edward S. Rambousek, Fairview Park, speaking on arteriosclerotic heart disease.

Dr. Harold Feil was chairman. Moderators of the three panels at the Academy of Medicine session, cosponsored by the Cleveland Area Heart Society, were Drs. Jerome Liebman, Herman K. Hellerstein and Arthur D. Nichol.

The medical opinion of the surgical views were expressed by Dr. Charles K. Friedberg, director of cardiology at Mt. Sinai Hospital, New York City, and associate clinical professor of medicine at Columbia University.

* * *

An extensive Sabin oral polio vaccine program was launched by the Academy of Medicine of Cleveland and Cuyahoga County early in May, in cooperation with many other local organizations. Early announcements reported that more than 700 physicians had signed up to participate.

## Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

### STARK

Another in the series of public health forums was held in Canton on April 25 at the Timken High School auditorium. The forums are sponsored jointly by the Stark County Medical Society, the Canton Academy of Medicine and the *Canton Repository.*

Speakers were Dr. Jack Yahraus, internist; Dr. William B. Epps of Massillon, general practitioner;


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Dr. Melvin W. Harris, internist, and Dr. Dudley Fetzer, pediatrician.

Their panel-type program on problems of weight and diet and the question-and-answer period which followed were moderated by Gervis S. Brady, public relations counsel for the medical societies.

### SUMMIT

"Physical Fitness for Physicians" was the theme of the May 1 Summit County Medical Society program. Dinner was served at the Holiday Inn followed by a panel discussion. Participants included "Red" Cochran of the University of Akron; Laurence Golding, Ph. D., Kent State University; Edward A. Sawan, M. D., Paul L. Weygandt, M. D., and Donald T. Hardesty of the YMCA. Don W. McCoy, M. D., was moderator.

* * *

The annual Golf Day of the Summit County Medical Golfers Association was held at the Congress Lake Country Club. The tournament was followed by dinner at the club.

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

### BELMONT

The Belmont County Medical Society had as guest speaker on May 10 Dr. William H. Havener, Department of Ophthalmology, Ohio State University, who spoke on "Management of Eye Trauma." The dinner meeting was at the Belmont Hills Country Club.

## Ninth District

(COUNCILOR: CHESTER H. ALLEN, M. D., PORTSMOUTH)

### JACKSON

Wednesday evening (April 25) the social security office of Portsmouth, Ohio presented a program, covering the disability provisions of the Social Security Act, to the Jackson County Medical Society. The program was held in the County Commissioner's office in the court house in Jackson. It was arranged by John R. Chatfield and William Greber, manager and field representative respectively, of the Portsmouth office through the cooperation of the Medical Society President, Dr. John Cook of Oak Hill, Ohio.

Mr. Chatfield had as his guests James L. Wallace and Dr. Beryl Oser of the Disability Determination Section, Bureau of Vocational Rehabilitation, Columbus. A movie "The Disability Decision" was shown and disability requirements and problem areas were discussed.—*Wellston Sentinel.*

## Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

### ROSS

Ross County Medical Society, at a meeting at the Lynne House, Thursday (April 5), adopted a resolu-


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Surgical Technic, Two Weeks, July 23, September 10
Surgery of Colon & Rectum, One Week, September 17
General Surgery, One Week, September 17
Urology, Two Weeks, October 29
Vaginal Approach to Pelvic Surgery, June 25, August 6
Obstetrics, General & Surgical, Two Weeks, July 16
Gynecology, Office & Operative, Two Weeks, September 17
Proctoscopy & Sigmoidoscopy, One Week, September 10
General Practice Review, One Week, October 8
Gallbladder Surgery, 3 Days, June 18, October 8
Surgery of Hernia 3 Days, June 21, October 11
Advances in Medicine, One Week, October 15
Advances in Surgery, One Week, December 10
Blood Vessel Surgery, One Week, October 22
Board of Surgery Review — Part I, Two Weeks, Nov. 5
Board of Surgery Review — Part II, Two Weeks, Nov. 26
Fractures & Traumatic Surgery, Two Weeks, October 1
Diagnostic Radiology, Two Weeks, October 29

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Ref.: Karnaky, K. J., Tri-State Med. J., Sept. 1961. Burrus, S. Jr., Am. J. Obst. & Gynec., Aug. 1960. Karnaky, K. J., Tri-State Med. J., June, 1960. Schaefer, G., Clin. Obst. & Gynec., June, 1959. Liswood, R., Obst. & Gynec., May, 1959.

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tion to co-sponsor a diabetic detection survey in cooperation with the health department.

It is expected that the survey will reveal 200 unknown diabetics in Ross County, Dr. David McKell, secretary, said.

Dr. Lloyd E. Larrick, a director of Christ Hospital, Cincinnati, and a former Chillicothean, was the essayist on the topic "The Doctor and the Hospital."

He also discussed the King-Anderson bill and presented his testimony opposing this bill.—*Chillicothe Gazette.*

* * *

Speaker for the May 3 meeting of the Academy was Dr. John W. Sigler, a native of Chillicothe and presently associate physician in the Henry Ford Hospital, Detroit. His subjest was "Rheumatoid Spondylitis."

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

Ninety-nine persons attended the 15th Annual Medical Symposium of Lorain County Medical Society at the Oberlin Inn, May 9. The four lectures presented by a Team from Rochester University School of Medicine and Dentistry Atomic Energy Project dealt with "Medical Aspects of Acute and Chronic Radiation Injury."

In addition to members of the Medical Society, key hospital personnel were invited to attend, and residents and interns from the hospitals in the county were again guests of the Society.

Dr. R. S. Van Dervort, Education Committee Chairman, presented the speakers:

Marylou Ingram, M. D., "Account of a Radiation Accident," and "Therapy of Acute Radiation Accident Casualties."

Prof. Herbert Mermagen, "Recognition and Control of Hazards in Radiation Work."

J. Newell Stannard, Ph. D., "Hazards Associated with Internally Deposited Radioactive Materials."

Between the afternoon and evening sessions physicians inspected the Carlisle Township Fire Department's Rescue & Salvage Truck at the invitation of Chief Harold Bruce, Sr., who brought this well equipped facility to the Oberlin Inn for this purpose.

### Occupational Health Congress

Physicians and industrial health experts from all sections of the nation will gather in Boston Oct. 2-3 for the 22nd Congress on Occupational Health. The two-day meeting at the Somerset Hotel is sponsored by the American Medical Association's Council on Occupational Health.

The national congress serves as a meeting for the formal presentation of scientific papers on occupational health as well as a forum in which occupational health problems can receive the attention of acknowledged experts in this field.


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# Hospital Planning Project...

## Extensive Study in Central Ohio Area Will Set Stage for a Regional Planning Council

THE OHIO HOSPITAL ASSOCIATION will participate in a Service Demonstration Project to develop a prototype regional hospital planning council.

Edgar O. Mansfield, president of the OHA, met with officials of the Columbus Hospital Federation and the Ohio State University College of Medicine on April 23, and has announced that the U. S. Public Health Service has chosen Central Ohio as the study area. The Columbus Hospital Federation will serve as the administrative institution for the project. The program will be financed by a USPHS grant of $168,240.

During a three year period the project will study hospitals and related health services in a 35-county area approximately co-terminal with the OHA Central District. The project staff will serve as a service organization on a consulting basis to the entire district at no cost to the individual hospital.

The Ohio Department of Health, the Ohio State College of Medicine, the Ohio State Medical Association and Central Hospital Service (Blue Cross) will also cooperate in conducting the project. Serving on the project for the OSMA will be Mr. Charles S. Nelson, Executive Secretary of the Association, and Dr. Drew Arnold, Columbus.

The Ohio Hospital Association has been working since December, 1961, with other sponsoring agencies to develop a definite plan for the setting up of the planning council.

The project will seek to develop methods for collection, analysis and dissemination of information about existing hospitals and related health services, and to develop criteria to assist in the establishment of priorities for renovation and construction of hospitals and related health services.

Delbert L. Pugh, executive director of the Columbus Hospital Federation, stated that the project will "field test" principles established in the recent Public Health Services publication *Areawide Planning for Hospitals and Related Health Services*. Richard L. Meiling, M. D., Dean of the College of Medicine at Ohio State University, stated that the project will also review present patterns in postgraduate medical education and training within the area and attempt to find better methods of disseminating new developments and techniques in medical practice within the region.

Mr. Pugh will serve as project administrator, and Peter A. Volpe, M. D., has been employed as director of regional planning and Edward A. Lentz as associate director.

Dr. Volpe has been Administrator of University Hospital and the Ohio State University Health Center since 1955 and Mr. Lentz has been director of health planning of the United Community Council of Columbus and Franklin County since 1957. Mr. Paul R. Gingher, president of the Columbus Hospital Federation, emphasized that Columbus, as the center of the regional planning area, will continue to benefit from the services of these two citizens who have made many valuable contributions to the health and welfare of the community.

The June 14 Central District Council meeting will be devoted to a complete discussion and explanation of the Regional Hospital Planning Project.

### Lions Club Adds To Eye Research Fund

The Ohio Lions Eye Research Foundation has given an additional $5,000 to the Ohio State University College of Medicine. The latest gift brings to $150,000 the amount of money contributed to Ohio State University for eye research.

Dr. Makley said the new gift will help finance continuing investigation of uveitis, a group of inflammatory disorders of the eyeball and eyelid that are the principal causes of blindness today. The Lions Association has directly supported this study for nearly seven years.

### School Health Program

A session on school health under joint sponsorship of the American School Health Association and the American Medical Association's Department of Health Education will be held in conjunction with AMA Annual Session in Chicago. The school health meeting is at the Palmer House, Chicago, Sunday, June 24, beginning at 7:30 p. m.

The physicians in Washington State are cordially extending an invitation to doctors throughout the country who plan to visit the Seattle World's Fair this September to coincide their trip with the 73rd Annual Meeting of the Washington State Medical Association in Spokane, September 16-19.

# Ad Astra

**Henry John Austin**, M. D., formerly of Elyria; Cleveland-Pulte Medical College, 1899; aged 86; died April 22; former member of the Ohio State Medical Association. Dr. Austin practiced in Elyria from shortly after World War I until the time of his retirement 10 years ago. He had been living in Hollywood, Fla., and only recently moved to Ann Arbor, Michigan. Before World War I, he practiced in Ashtabula and was county coroner there. As a veteran of the war, he was a member of the American Legion; also a member of the Elks and Odd Fellows Lodges. Besides his son, a sister survives.

**Fred Fletcher**, M. D., Columbus; Jefferson Medical College of Philadelphia, 1900; aged 82; died April 15; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A physician and surgeon of long standing in Columbus, Dr. Fletcher was associated with the former Starling Medical College and later with the Medical College of Ohio State University. He was a past-president and former secretary of the Academy of Medicine of Columbus. During World War I he served with the Army Medical Corps and attained the rank of lieutenant colonel.

**John Pearson Fulton**, M. D., Akron; Western Reserve University School of Medicine, 1918; aged 77; died April 10; member of the Ohio State Medical Association and the American Medical Association. Dr. Fulton practiced medicine and surgery for some 44 years in Akron. Surviving are his widow, a daughter, a sister and a brother.

**Ray D. Gardner**, M. D., Cleveland; University of Minnesota Medical School, 1909; aged 80; died April 19. A practicing physician in the Cleveland area for many years, Dr. Gardner retired in 1952. He is survived by his widow, two sons, a brother and a sister.

**William Wilson Lynd**, M. D., Ironton; Miami Medical College, Cincinnati, 1903; aged 83; died April 27; member of the Ohio State Medical Association and the American Medical Association. A native of Ironton, Dr. Lynd returned there to practice upon completion of his medical training and remained in practice for 59 years. He served for some 20 years as county coroner and was active in such local organizations as the Red Cross and the Methodist Church. Survivors include two sons, a brother and a sister.

**Paul Guthrie Moore**, M. D., Cleveland; Western Reserve University School of Medicine, 1910; aged 77; died April 23; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Otolaryngology; Fellow of the American College of Surgeons. A specialist in ophthalmology and industrial surgery for many years in Cleveland, Dr. Moore was former chief of the ophthalmology service at City Hospital. Among appointment was that as trustee of Western Reserve University. Survivors include two sons.

**Alonzo Solon Neely**, M. D., Urbana; Kentucky School of Medicine, 1904; aged 83; died April 17. A practitioner for many years in Indianapolis, Ind., Dr. Neely was living in retirement at Urbana. Survivors include his widow, a daughter, a son, a sister and a brother.

**George Dawson Nicholas**, M. D., Elyria; Cleveland-Pulte Medical College, 1901; aged 81; died May 3; member of the Ohio State Medical Association and the American Medical Association. A practitioner in Elyria for some 52 years, Dr. Nicholas was physician for the Ohio Edison Company and the Bendix-Westinghouse Air Brake Company. His widow survives.

**William Nuss**, M. D., San Marino, Calif. (formerly of Cleveland); University of Wooster, Medical Department, Cleveland, 1899; aged 90; died April 14. A native of Cleveland and former practitioner there, Dr. Nuss moved to California in 1919. He is survived by a brother and a sister.

**Jacob Saltzman**, M. D., Cleveland; University of Cincinnati College of Medicine, 1923; aged 65; died April 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Saltzman had been a practicing physician in Cleveland since 1923. Affiliations included memberships in several fraternal groups and in the Temple. Survivors include his widow, two daughters and a sister.

**Ernst Schmerl**, M. D., Toledo; Friedrich - Wilhelms University Faculty of Medicine, 1923; aged 65; died April 23; member of the Ohio State Medical Association, the American Medical Association and the Association for Research in Ophthalmology. Dr. Schmerl moved to Toledo in 1945 as a member of the staff of the Toledo Hospital Institute for Medical

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Research, later going into private practice. Surviving are his widow, a son, a daughter and two brothers.

**Oscar H. Sellenings,** M. D., Napoleon; New York University College of Medicine, 1904; aged 83; died April 26; former member of the Ohio State Medical Association. A resident of Napoleon for about 14 years, Dr. Sellenings practiced for many years previously in Columbus where he specialized in pediatrics and served on the Columbus Board of Health. During World War I he served in France with the American Red Cross. A member of the Episcopal Church, he is survived by his widow, a son and a brother.

**Irwin Stover,** M. D., Toledo; University of Toronto Faculty of Medicine, 1921; aged 67; died April 20; member of the Ohio State Medical Association, the American Medical Association and the American Diabetes Association. A native of Ontario, Canada, Dr. Stover served virtually all of his professional career in Toledo. A member of the Masonic Lodge, he is survived by his widow and a sister.

**Ralph Henry Vance,** M. D., Wilmington; Eclectic Medical College, Cincinnati, 1917; aged 71; died April 22; member of the Ohio State Medical Association. Dr. Vance served in the Army Medical Corps during World War I and then began practice in Pleasant Plain. In 1936 he moved to Wilmington. He was a member of the Rotary Club, several Masonic bodies and the Methodist Church. Surviving are his widow and a son.

**James Stanley Williams,** M. D., Massillon; University of Cincinnati College of Medicine, 1913; aged 76; died April 11; member of the Ohio State Medical Association and the American Medical Association. Dr. Williams practiced in Massillon from 1915 until his recent retirement, except for time served in the Medical Corps during World War I. He was a member of the local American Legion post, was active in local projects such as the school athletic program and the Red Cross; was a member of the United Church of Christ, and several Masonic bodies. Survivors include his widow, two sons, James of North Canton, and Dr. Robert H. Williams of Williamsport, Pennsylvania.

**Richard Mills Wahl,** M. D., Cristobal, Canal Zone; Western Reserve University School of Medicine, 1957; aged 32; died April 9. Dr. Richard Wahl, son of the late Dr. Spencer Wahl of Cleveland, was doing residency work at Gorgas Hospital. He is survived by his widow, a son, his mother and a sister.

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The Food and Drug Administration has seized two antibiotic preparations charging that promotional literature sent to physicians differs from the labeling which was the basis of the original safety clearance. Seized were a quantity of Tain Oral Suspension and Tain Antibiotic Decongestant Analgesic tablets, shipped by Dorsey Laboratories, Lincoln, Nebraska.

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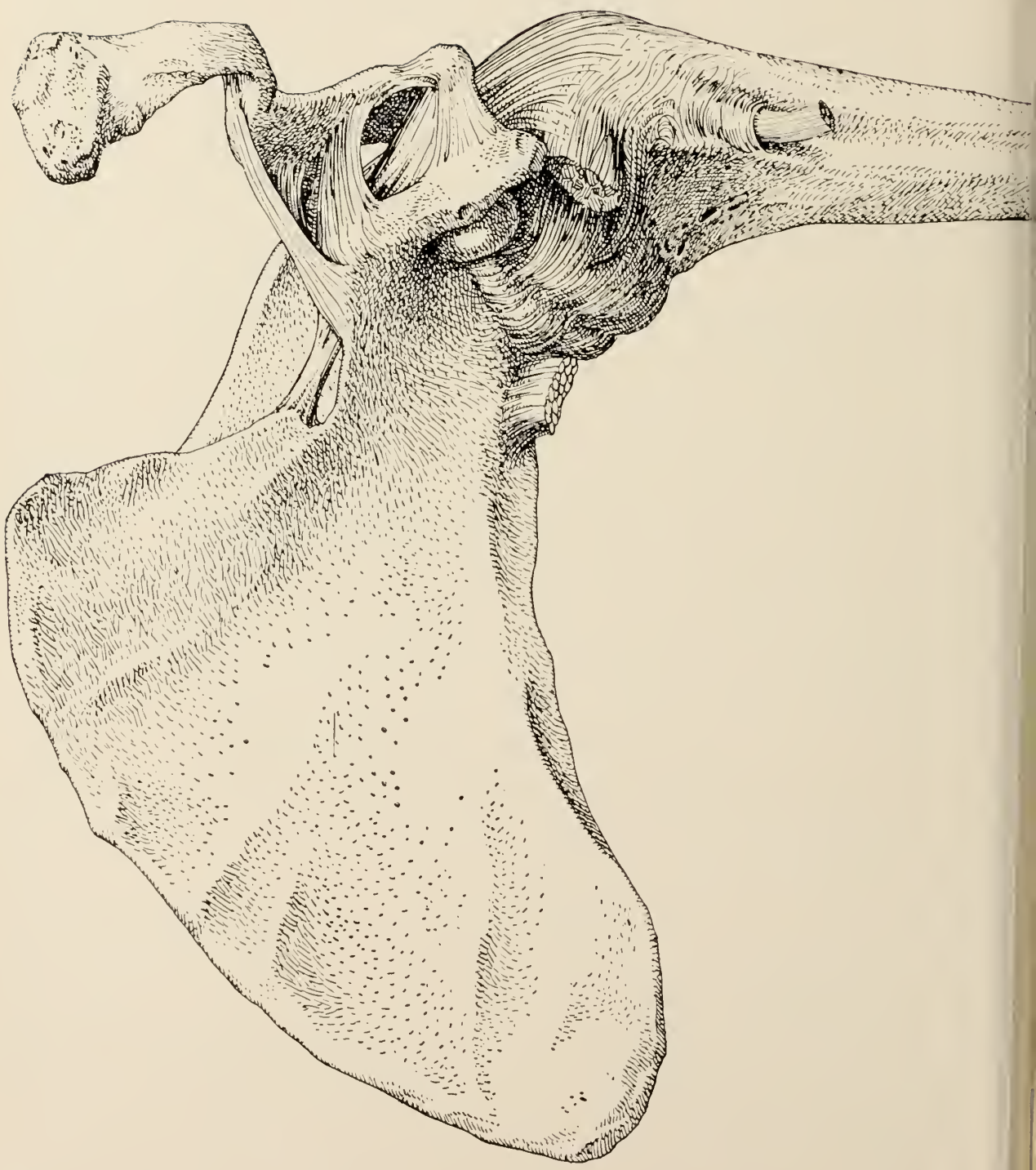
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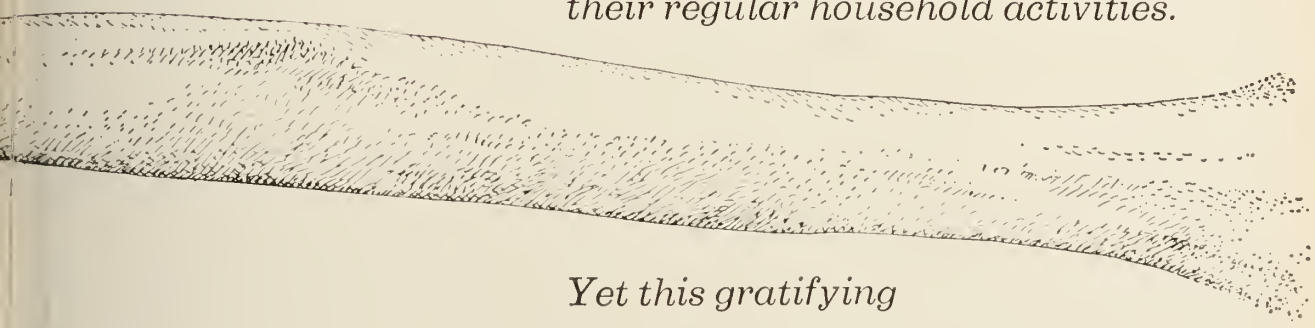
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# Activities of Woman's Auxiliary . . .

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## HAMILTON

Dr. James K. Robinson, associate professor of English and senior research associate, Department of Psychiatry of the University of Cincinnati, highlighted the April 17 luncheon meeting at the Academy of Medicine with an absorbing discussion of "Physicians in Literature." Program chairman for the day, Mrs. Charles Hofling, was assisted by Mrs. John MacLeod. Mrs. N. G. Amato served as hospitality chairman with Mrs. Robert Anzinger as her vice-chairman.

A recommendation to assist the Academy of Medicine in the TV presentation of the facts of the King-Anderson Bill on May 13, was unanimously approved.

Illustrative material concerning Mental Health Week was distributed by Mrs. Edward Cole, chairman, and all members were urged to become genuinely interested in mental health problems.

The Health Careers Club sponsored its second workshop of the year at the Academy of Medicine on April 28. Guest speaker was from Miami University.

On April 23, Mrs. George D. J. Griffin, Legislative Committee chairman, and Mrs. Carl Schilling, president of the Auxiliary, journeyed to Dayton to orient the Auxiliary there in ways of combatting the King-Anderson Bill.

## HURON

Mrs. William B. Holman was elected President of the Woman's Auxiliary to the Huron County Medical Society for the coming year. Assisting Mrs. Holman will be president-elect, Mrs. William Corwin, vice-president, Mrs. William Graham, secretary, Mrs. Earl McLoney, and treasurer, Mrs. Charles Edel.

A report was given by Mrs. J. V. Emery of the trip to Ohio State University March 31 for Paramedical Careers Day. Twenty-two students from Huron County attended the session.

Two loans are now available through the Auxiliary for worthy students who need financial assistance to pursue a career in the Paramedical field.

## SCIOTO

More than 40 members of the Senior Citizens Club were guests of the Woman's Auxiliary to Scioto County Medical Society at the April meeting held at Madonna Hall, the nurses home at Mercy Hospital.

The Senior guests were welcomed by Mrs. Clyde M. Fitch, who also gave a brief summation of the Auxiliary's projects, which include many types of health programs.

The Clay local high school debate team, which won the state championship, presented its debate on "Resolved that the Federal Government Should Equalize Education and Opportunity by Means of Grants to the States for Public Elementary and Secondary Schools." Members of the team are Richard Morrow, David Smith, William Gwynne and Dianne Duty with Susan Reed as time keeper.

Also on the program, poetry was recited by Miss Minerva Norris and a humorous selection was read by Charles C. Bennett. Mrs. Evelyn Gearhart and Mrs. Bertha Schmid sang duets with Mrs. Kathryn Charlton as accompanist.

Several arrangements were sung by the Mercy Hospital Student Nurse Chorus. A social hour concluded the afternoon affair.

The hostesses were Mrs. A. L. Berndt, chairman of community services; Mrs. Fitch, Mrs. B. U. Howland, Mrs. P. D. Weems, Mrs. Ross Moore Gault, Mrs. Wells McCann, Mrs. William M. Singleton, Mrs. W. D. Michlethwaite and Mrs. C. W. Wendelken.

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## Selective Service Status of Physicians Is Explained

Following is a brief summary of the present status of Selective Service as it relates to physicians:

During the calendar year 1961 three Selective Service calls for physicians were issued. This was the first time such calls have been necessary for several years. However, during the past year there was a decrease in volunteers and an increase in the numbers required by the Armed Forces as a result of the mobilization program. This increase in requirement was obtained by:

1. Discontinuing the acceptance of resignation of Regular Officers.

2. Denying release of those Reserve Officers who had voluntarily extended their active duty for an indefinite time.

3. Selective Service call up of 1,025 physicians.

4. Call to active duty of National Guard and Reserve Units with Medical Officers attached.

Because physicians, dentists and other medical specialists, generally speaking, are liable for military service until age 35, and because they may be called as a special group, they were given the following considerations:

1. Those in a Reserve status who were called as filler personnel on or after September 1, 1961 and who had completed at least 21 months previous active duty were given the opportunity to be released after the activation of the unit.

2. Those Reserve Officers on active duty serving only their required two years were released at the end of their tour.

The physicians called up by Selective Service were those in the youngest age group who had completed their internship. This group, therefore, included almost exclusively first year residents and physicians just beginning private practice. Since the call was based on age it was not evenly distributed and some hospital training programs suffered a depletion of their first year residents while others were untouched.

Because of the possibility of future Selective Service calls for physicians in time of a crisis it would be well to consider the measures which are available to ameliorate the effect on hospital staffs and civilian communities. These are:

**1. Appeal of classification of 1-A (available for military service) to the Appeal Board.**

Shortly after completion of internship, physicians are normally classified by Selective Service in Class 1-A. An appeal may be made within ten days after receipt of this classification by filing with the local board a written notice of appeal. If the physician is located in an area other than that covered by his local board he may request that his appeal be submitted to the appeal board having jurisdiction over the area where he resides.

**2. Request for determination of essentiality.**

A physician who receives a Selective Service induction notice may, if he is essential to his community or hospital and if his essentiality can be documented, request a determination of such essentiality from his local or State Selective Service Advisory Committee. Copies should be sent to the advisory committee where he is located if this is different from the committee governing the area of the board where the physician is registered. Such a request may also be directed to the National Advisory Committee to the Selective Service System, Washington, D. C.

**3. Delay in reporting to active duty.**

Physicians who have received induction notices and have been commissioned may apply to the Armed Service in which they are commissioned for a delay in reporting to their duty station. Such request must be supported by evidence of essentiality or severe personal hardship.

For those physicians who do not wish to subject themselves to the uncertainties of the draft, the Armed Forces Physicians' Appointment and Residency Consideration Program (Berry Plan) provides for a reserve commission with entry on active duty at one of the following times:

1. Immediately upon completion of internship.
2. As late as one year following internship.
3. Upon completion of residency training in specialties required by the Armed Forces.

Application may be made for participation in this program early during the intern year. Acceptance into any of the three categories is dependent upon the projected needs of the Armed Services.

(Prepared at the request of the AMA Council on National Security by Eugene V. Jobe, M. D., Medical Liaison Representative, AMA Washington Office, and James E. Fitzgerald, M. D., Member, AMA Council on National Security, April 9, 1962.)

### Health Insurance Coverage For Aged Soaring

A look at the record of growth nationally reveals that the number of persons obtaining some form of health insurance is increasing at a much faster rate among those 65 and over than any other age group. In 1952, 26 per cent of the aged — one of four — had health insurance protection. By 1961, this proportion more than doubled to reach an estimated 53 per cent of a significantly larger total population. Health insurance coverage for the elderly is expanding at a considerably faster rate than the growth of the aged population itself.— Health Insurance Council Review.

# Instructions To Scientific Contributors

1. **Exclusive Publication.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **Correspondence.** Address all correspondence relating to publication of scientific papers to: The Editor, The Ohio State Medical Journal, Room 1005, 79 East State Street, Columbus 15, Ohio.

3. **Manuscripts.** Manuscripts should be submitted in the original on standard 8½"x11" white typing paper. The entire text, including case reports and lists of references, should be typed double or triple space with margins of at least one inch on all sides. A copy of the manuscript should be retained by the Author.

4. **Tables and Charts.** Tables and charts that can be set in type may be included, and there will be no charge for their reproduction.

5. **Illustrations.** Illustrations requiring engraving (photographs, drawings, graphs, etc.) will be submitted to an engraver for an estimate of cost. *The Journal* will assume $25 of this expense and the Author will be billed directly by the engraver for the remainder.

Each illustration should bear the figure number and the author's name on the back. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints. Legends for the figures should be written on separate paper.

Used photographs and drawings will be returned after the article is published, if requested within 30 days after publication. Plates will be sent to the Author after the article has been published.

Obtaining permission for the taking and publishing of photographs is the responsibility of the author.

6. **References.** To conserve space and expense, lists of references should be limited to those essential to the subject and to which actual reference is made in the text.

References should be listed in the order of their appearance in the text.

Each reference should include, in this order: Author's last name and initials, title of the article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, month (day of month, if weekly), and year, e. g.

"2. Doe, J. Q., and Roe, R. X.: How to Go About It, Ohio State M. J., 13:24-30 (Feb.) 1920."

Authenticity and accuracy of references are the responsibilities of the Author.

7. **Identification of Patients.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

8. **Reprints.** An order blank for reprints with a table covering cost will be sent with the galley proof to the senior author.

Requests for reprints should be addressed to the Author.

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# COUNTY SOCIETIES' OFFICERS AND MEETING DATES

## FIRST DISTRICT

ADAMS—Hazel L. Sproull, President, West Union; Kenneth C. Jee, Secretary, Winchester. 3rd Thursday, January, April, July and October.

BROWN—Charles W. Hannah, President, Sardinia Medical Clinic, Sardinia; Carl A. Liebig, Secretary, Box 245A, R.R. 1, Georgetown.

BUTLER—James L. Sawyer, President, 2650 Stevens Ave., Medical Arts Bldg., Middletown; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. Last Wednesday of alternate months.

CLERMONT—Phillips F. Greene, President, Box 509, Rt. 1, New Richmond; Richard K. Lancaster, Secretary, 684 Batavia Pike-Vermona Drive, Cincinnati 45. 3rd Wednesday, monthly.

CLINTON—Foster J. Boyd, Jr., President, 291 N. South St., Wilmington; Emily B. Buchanan, Secretary, 255 Prairie Ave., Wilmington. 1st Tuesday, monthly.

HAMILTON—Edward Woliver, President, 2605 Burnet Ave., Cincinnati 19; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 2. 3rd Tuesday, monthly, September through May.

HIGHLAND—J. Martin Byers, President, 628 Jefferson St., Greenfield; David S. Ayres, Secretary, 1440 N. High St., Hillsboro. 1st Wednesday, every other month.

WARREN—Ray E. Simendinger, President, 21 E. Main St., Lebanon; D. Paul Ward, Secretary, Box 18, Pleasant Plain. 2nd Tuesday, monthly.

## SECOND DISTRICT

CHAMPAIGN—Victor R. Frederick, President, 848 Scioto St., Urbana; Myron J. Towle, Secretary, 848 Scioto St., Urbana. 2nd Wednesday, monthly.

CLARK—George A. Smith, President, 908 N. Fountain Ave., Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, 35 S. Spring St., Springfield. 3rd Monday, monthly.

DARKE—James H. Dickey, President, 215 E. Fourth St., Greenville; Charles E. Gariety, Secretary, 300 East Third St., Greenville. 3rd Tuesday, monthly.

GREENE—Alvin B. Salisbury, Jr., President, 11 E. Xenia Drive, Fairborn; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly except July and August.

MIAMI—Dale A. Hudson, President, 221 Orr-Flesh Bldg., Piqua; Jack P. Steinhilber, Secretary, 513 W. High St., Piqua. 1st Tuesday, monthly.

MONTGOMERY—Lynne E. Baker, President, 530 Fidelity Bldg., Dayton 2; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Bldg., Dayton 2. 1st Friday, monthly.

PREBLE—Michael O. Phillips, President, 228 N. Barron St., Eaton; Willard Clark, Jr., Secretary, 228 N. Barron St., Eaton.

SHELBY—Ned A. Smith, President, 739 Spruce Ave., Sidney; William F. Mentges, Secretary, 627 N. West Ave., Sidney. 2nd Tuesday, monthly.

## THIRD DISTRICT

ALLEN—Melvin A. Mulvania, President, 512 Steiner Bldg., Lima; Thomas D. Allison, Secretary, 401 Steiner Bldg., Lima. 3rd Tuesday, monthly, except June, July, August.

AUGLAIZE—Robert S. Oyer, President, 310 Perry St., Wapakoneta; Robert S. Sobocinski, Secretary, 7 So. Blackhoof St., Wapakoneta. Called meetings.

CRAWFORD—L. James Barth, President, West Main St., New Washington; Daniel P. Kenny, Secretary, Tiffin St., New Washington. 3rd Thursday, monthly.

HANCOCK—Benjamin H. Saunders, Jr., President, 1900 S. Main St., Findlay; Thomas W. Darnall, Secretary, 1809 S. Main St., Findlay. 3rd Tuesday, monthly.

HARDIN—Jack C. Lindsey, President, 214 N. Main St., Kenton; Robert B. Elliott, Secretary, 302 N. Main St., Ada. 2nd Tuesday, monthly.

LOGAN—F. Blair Webster, President, 130 N. Main St., Bellefontaine; Douglas W. Beach, Secretary, 1008 N. Main St., Bellefontaine. 1st Friday, monthly.

MARION—Frank V. Murphy, Jr., President, 399 E. Church St., Marion; Vernon A. Nichols, Secretary, 1040 Delaware Ave., Marion. 1st Tuesday, monthly, except June, July and August.

MERCER—Donald J. Schwieterman, President, Maria Stein; Robert W. Albers, Secretary, 301 North Cedar St., Coldwater. 3rd Thursday, monthly.

SENECA—Robert R. Schwalenberg, Jr., President, 34 W. Market St., Tiffin; Oswald G. Burkhart, Jr., Secretary, 19 E. Perry St., Tiffin. 3rd Tuesday every month, alternating between Tiffin and Fostoria.

VAN WERT—Edward E. White, President, 704 E. Central Ave., Van Wert; Thomas R. Wilson, Secretary, Van Wert Co. Hospital, Van Wert. 1st Friday, monthly.

WYANDOT—John M. Thompson, President, 216 N. Main St., Upper Sandusky; Donald P. Smith, Secretary, Sycamore. 2nd Tuesday, monthly.

## FOURTH DISTRICT

DEFIANCE—Francis M. Lenhart, President, 1075 E. Second St., Defiance; William S. Busteed, Secretary, 509 Fourth St., Defiance. 1st Saturday, monthly.

FULTON—William J. Neal, President, 224 N. Defiance St., Archbold; Robert A. Gerrick, Secretary, 117 Edgewood St., Delta. 2nd Tuesday, quarterly.

HENRY—Raymond J. Manahan, President, 506 N. Perry St., Napoleon; Thomas F. Tabler, Secretary, 332 Railway Ave., Holgate. 1st Tuesday, monthly.

LUCAS—William A. Blank, President, 1838 Parkwood Ave., Toledo 2; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—F. Kraft Ritter, President, 232 E. Second St., Port Clinton; V. William Wagner, Secretary, 122 E. Perry St., Port Clinton. 2nd Thursday, monthly.

PAULDING—Gaile L. Doster, President, 118 W. Jackson St., Paulding; John H. Schaefer, Secretary, Walnut & Perry Sts., Paulding. Called meetings.

PUTNAM—Walter W. Donahue, President, 104 B. & M. Bldg., Leipsic; John R. Brown, Secretary, 135 S. Hickory St., Ottawa.

SANDUSKY—Richard H. Belch, President, 400 Chestnut St., Fremont; Edwin C. Swint, Secretary, 307½ W. State St., Fremont.

WILLIAMS—Robert J. Bemis, President, 112 W. Main St., Montpelier; Robert G. Sheperd, Secretary, 104 N. Main St., West Unity.

WOOD—James R. Janney, President, 920 N. Main St., Bowling Green; William S. Rothe, Secretary, 920 N. Main St., Bowling Green. 3rd Thursday, monthly.

## FIFTH DISTRICT

ASHTABULA—William J. McCarthy, President, 211 Park Place, Ashtabula; Reginald W. Shelby, Secretary, 252 Center St., Ashtabula. 2nd Tuesday, monthly.

CUYAHOGA—John Dexter Osmond, Jr., President, 10515 Carnegie Ave., Cleveland 6; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 6.

GEAUGA—Kayoshi Masuoka, President, Medical Center, Chardon Plaza, Chardon; Raymond I. Smith, Secretary, P.O. Box 208, Chardon. 2nd Friday, monthly.

LAKE—Maxwell E. Burnham, President, 358 Bank St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor. 2nd Wednesday, monthly, of January, March, May, September and Novemher.

## SIXTH DISTRICT

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PORTAGE—L. Fred Bissell, President, 12 New Hudson Rd., Aurora; Don P. VanDyke, Secretary, 607 East Main St., Kent. 3rd Tuesday, monthly.

STARK—Graydon D. Underwood, President, Navarre Deposit Bank Bldg., Navarre; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., Canton 2. Second Thursday, monthly.

SUMMIT—Frank M. McDonald, President, 437 Ohio Building "B", Akron 8; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Bldg., Akron 8. 1st Tuesday, monthly.

TRUMBULL—Thomas E. Wilson, President, 438 N. Park Ave., Warren; Mrs. Kay Ticknor, Executive Secretary, P. O. Box 1328, Warren. 3rd Wednesday, monthly.

## SEVENTH DISTRICT

BELMONT—Fred W. Cook, President, 111 S. 4th St., Martins Ferry; Bertha M. Joseph, Secretary, 100 S. 4th St., Martins Ferry. 3rd Thursday, monthly.

CARROLL—Thomas J. Atchison, President, 292 E. Main St., Carrollton; Jack L. Maffett, Secretary, 24 2nd St., N.E., Carrollton. 1st Thursday, monthly.

COSHOCTON—N. Harry Carpenter, President, 713 Main St., Coshocton; Harold W. Lear, Secretary, 133 S. 4th St., Coshocton. 2nd Tuesday, monthly.

HARRISON—James Z. Scott, President, Main St., Box 512, Scio; George E. Henderson, Secretary, Main St., New Athens. Meetings held every three months.

JEFFERSON—Earl Rosenblum, President, 224 N. 4th St., Steubenville; Paul W. Ruksha, Secretary, 633 Lawson Ave., Steubenville. 2nd Tuesday, monthly.

MONROE—O. C. Jackson, President, Woodsfield; Byron Gillespie. Secretary, S. Main St., Woodsfield.

TUSCARAWAS—Eugene R. Hammersley, President, P.O. Box 355, Tuscarawas; Robert J. Kuba, Secretary, 319 Grant Ave., Dennison. 2nd Thursday, monthly.

## EIGHTH DISTRICT

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FAIRFIELD—Charles F. Clark, President, 214 Harmon Ave., Lancaster; Stephen R. Hodsden, Secretary, 1423 W. Market St., Baltimore. 2nd Tuesday, monthly.

GUERNSEY—Earl E. Conaway, President, 1198 Clark St., Cambridge; Darell J. Smith, Secretary, Rt. 3, Cambridge Medical Arts Bldg., Cambridge. 1st Thursday, monthly.

LICKING—Lawrence H. Miller, President, 205 S. Prospect St., Granville; James A. Quinn, Jr., Secretary, Newark Hospital, Newark. Last Tuesday, monthly.

## County Societies' Officers and Meeting Dates (Continued)

MORGAN—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta. Called Meetings.

MUSKINGUM—Rankin A. Nehinger, President, Third St., Roseville; Benjamin W. Gilliotte, Secretary, 821 Market St., Zanesville. 1st Tuesday, monthly.

NOBLE—Edward G. Ditch, Secretary, 415 Main St., Caldwell. 1st Tuesday, monthly

PERRY—Sydney N. Lord, President, E. Main St., Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—Clarence E. Ash, President, Marietta Memorial Hospital, Marietta; Tuathal P. O'Maille, Secretary, Marietta Memorial Hospital, Marietta. 2nd Wednesday, monthly.

### NINTH DISTRICT

GALLIA—Norman W. Pinschmidt, President, The Gallipolis Clinic, Gallipolis; Thomas P. Price, Jr., Secretary, The Holzer Clinic, Gallipolis. Last Thursday, monthly.

HOCKING—John W. Doering, President, 42 N. Spring St., Logan; Howard M. Boocks, Secretary, Court House, Logan. Called meetings.

JACKSON—John M. Cook, President, Oak Hill Hospital, Oak Hill; Brinton J. Allison, Secretary, Court House, Jackson. Called meetings.

LAWRENCE—Ralph F. Massie, President, 408 Washington St., Ironton; George Newton Spears, Secretary, 2213 South Ninth St., Ironton. Called meetings.

MEIGS—Joseph J. Davis, President, 306 N. 2nd St., Middleport; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy. Called meetings.

PIKE—Robert M. Andre, President, Lake White, Rt. 2, Waverly; Kenneth Wilkinson, Secretary, 330 E. Main St., Waverly. 1st Tuesday, monthly.

SCIOTO—Spencer W. Miller, President, 1021 9th St., Portsmouth; William E. Daehler, Secretary, 1004 24th St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President and Secretary, McArthur.

### TENTH DISTRICT

DELAWARE Don K. Michel, President, 98 W. William St., Delaware; Edward C. Jenkins, Secretary, 470 S. Sandusky St., Delaware. 3rd Tuesday, monthly.

FAYETTE Robert A. Heiny, President, 414 E. Court St., Washington, C. H.; James E. Rose, Secretary, 119 E. Market St., Washington C. H.

FRANKLIN Richard L. Fulton, President, 1211 Dublin Rd., Columbus 12; Mr. William Webb, Jr., Executive Secretary, 79 E. State St., Columbus 15. 3rd Monday, monthly, except May, June, July and August.

KNOX—Delbert C. Schmidt, President, 205 East Chestnut St., Mt. Vernon; Richard L. Smythe, Secretary, Medical Arts Bldg., Mt. Vernon. Usually 1st Wednesday, monthly.

MADISON—Sol Maggied, President, 15 E. Pearl, West Jefferson; Charles Terrill Hay, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—William S. Deffinger, President, Marengo; Joseph P. Ingmire, 28 W. High St., Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Francis W. Anderson, President, 416 E. Main St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Swank, President, 172 E. Main St., Chillicothe; David McKell, Secretary, 60 Central Center, Chillicothe. 1st Thursday, monthly, except June, July and August.

UNION—Walter R. Burt, President, West State St., Milford Center; May B. Zaugg, Secretary, 130 N. Maple St., Marysville.

### ELEVENTH DISTRICT

ASHLAND—Paul J. Sauder, President, 1109 Eastern Ave., Ashland; William H. Rower, Secretary, 1060 Claremont Ave., Medical Arts Bldg., Ashland. 1st Friday, monthly.

ERIE—Carl R. Swanbeck, President, 1218 Cleveland Rd., Sandusky; Donald B. Cuthbertson, Secretary, 421 Wayne St., Sandusky. Alternately, 3rd Tuesday and Thursday, monthly.

HOLMES—Neven P. Stauffer, President, W. Adams St., Millersburg; Luther W. High, Secretary, 109 S. Clay St., Millersburg. 2nd Wednesday, monthly.

HURON—John V. Emery, President, Box 269, Willard; Nino M. Camardese, Secretary, 12 Benedict Ave., Norwalk. 2nd Wednesday, every other month.

LORAIN—Roy E. Hayes, President, Elyria Medical Arts Bldg., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 214 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Nevin J. M. Klotz, President, 162 Main St., Wadsworth; Leroy G. Dalheim, Secretary, 220 East Liberty St., Medina. 3rd Thursday, monthly, except July and August.

RICHLAND—C. Karl Kuehne, President, 480 Glessner Ave., Mansfield; Carroll E. Damron, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—G. G. Stitzinger, President, 1800 Beall Ave., Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday, monthly.


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Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

ATTRACTIVE OFFICE FOR GENERAL PRACTICE with x-ray and dark room. Good hospital near by. Close to Cleveland - Akron - Youngstown. Will rent or sell outright or land lease contract. This community is planning to build a shopping center almost across the street from this office. Box 259, c/o Ohio State Medical Journal.

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APPROVED PSYCHIATRIC RESIDENCY for General Practitioners or others: First year appointment beginning July 1, 1963 in well integrated psychiatric training program associated with State University of Iowa Psychiatric Department and the University of Nebraska College of Medicine. Requirements: Must be a citizen of United States or have expressed an intention of becoming one; have completed internship four years prior to July 1, 1963, and have been in practice during that period. Time served in Armed Forces or residency training in some other specialty acceptable. Preference given to applicants under forty-five years of age. Annual stipend $12,000. Applications should be made immediately. Write W. C. Brinegar, M. D., Superintendent, Mental Health Institute, Cherokee, Iowa.

### Aerospace Medicine

The Department of Preventive Medicine at Ohio State University will hold its Ninth Annual Postgraduate Course in Aerospace Medicine Monday through Friday, September 10 - 14, in the Health Center. Attendance will be limited to 125 on a first-come, first-served basis.

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The President has issued an executive order, changing the name of the President's Committee on Employment of the Handicapped by deleting the word "physically" from its title.

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Dr. Joseph A. Freiberg, president of the American Orthopedic Association, attended a joint meeting of the AOA with the Japanese Orthopedic Association in Tokyo. He presented a paper on "Desmoid Tumors." Dr. Freiberg is associate professor of surgery and director of the orthopedic division in the University of Cincinnati College of Medicine.

# Coming Meetings . . .

**American Medical Association**, Annual Meeting, Chicago, June 24-28.

**American College of Surgeons, Ohio Chapter**, Pick-Ohio Hotel, Youngstown, September 14-15.

**American College of Surgeons**, Clinical Congress, Atlantic City, October 15-19.

**American Medical Association**, Clinical Meeting, Los Angeles, November 25-28.

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### Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

Ursula Mary Anderson, Columbus, University of Liverpool, England; Stephen G. Sinclair, East Liverpool, University of Pittsburgh; Cleve Carrington Odom, Athens, Vanderbilt University;

David Patton Agle, Cleveland, McGill University; Louis Luke Barich, Hamilton, University of Pittsburgh; Katharina M. Brugger-Hinzen, Dayton, University of Cologne, Germany; Renato Cutarelli, Cleveland, University of Rome, Italy; Cornelio B. Deogracias, Cleveland, University of Santo Tomas, P. I.

John K. Ebling, Cleveland, University of Michigan; Philip Michael Edelman, Milford, State University of New York; Rodolfo Garcia-Rodriguez, University of Mexico; Robert Paul Hardman, Yellow Springs, Harvard Medical College;

James Joseph Leonard, Columbus, Georgetown University; Kenneth A. Linstruth, Amherst, Albany Medical College; Teruko O. Little (f), Columbus, Tokyo Women's Medical University; Victor Manuel Malagon, Santo Domingo Medical School; Abdullah M. Okutan, Cleveland, University of Istanbul, Turkey; Jose Lingkod Paras, Fairfield, University of Santo Tomas;

Courtney P. Persinger, Cincinnati, Medical College of Virginia; Alfonso Z. Ricohermoso, Steubenville, University of Santo Tomas, P. I.; Mohamed S. Saydjari, University of Geneva; Naomi Green Scandlyn, Cincinnati, George Washington University; Frederick J. Sigda, Georgetown University; Ernest P. Smit-Vanrotte, Columbus, State University of Leiden, Holland; David A. Taft, Columbus, State University of Iowa; Pablo A. Zalduendo, University of Havana.

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*REFERENCES: (1) Roseman, E.: Neurology* **11**:912, 1961. *(2) Bray, P. F.: Pediatrics* **23**:151, 1959. *(3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.: M. Clin. North America* **12**:317, 1958. *(5) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C. Thomas, 1954, p. 190. (6) Ibid: Postgrad. Med.* **20**:584, 1956. *(7) Merritt, H. H.: Brit. M. J.* **1**:666, 1958. *(8) Carter, C. H.: Arch. Neurol. & Psychiat.* **79**:136, 1958. *(9) Thomas, M. H., in Green, J. R., & Stedman, H. F.: Epileptic Seizures. Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (10) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.*

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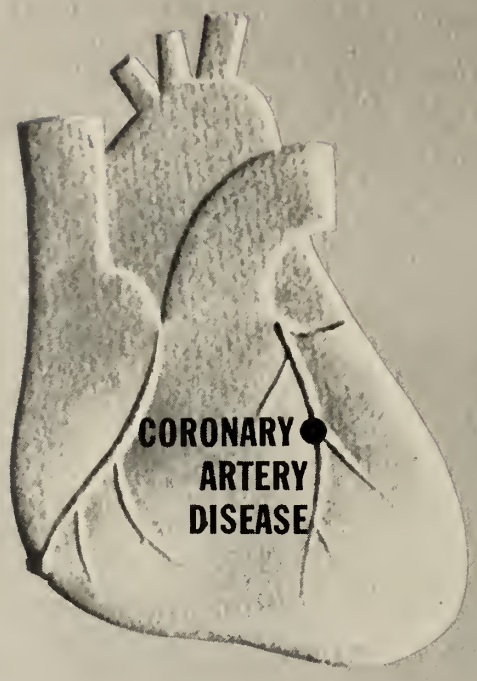
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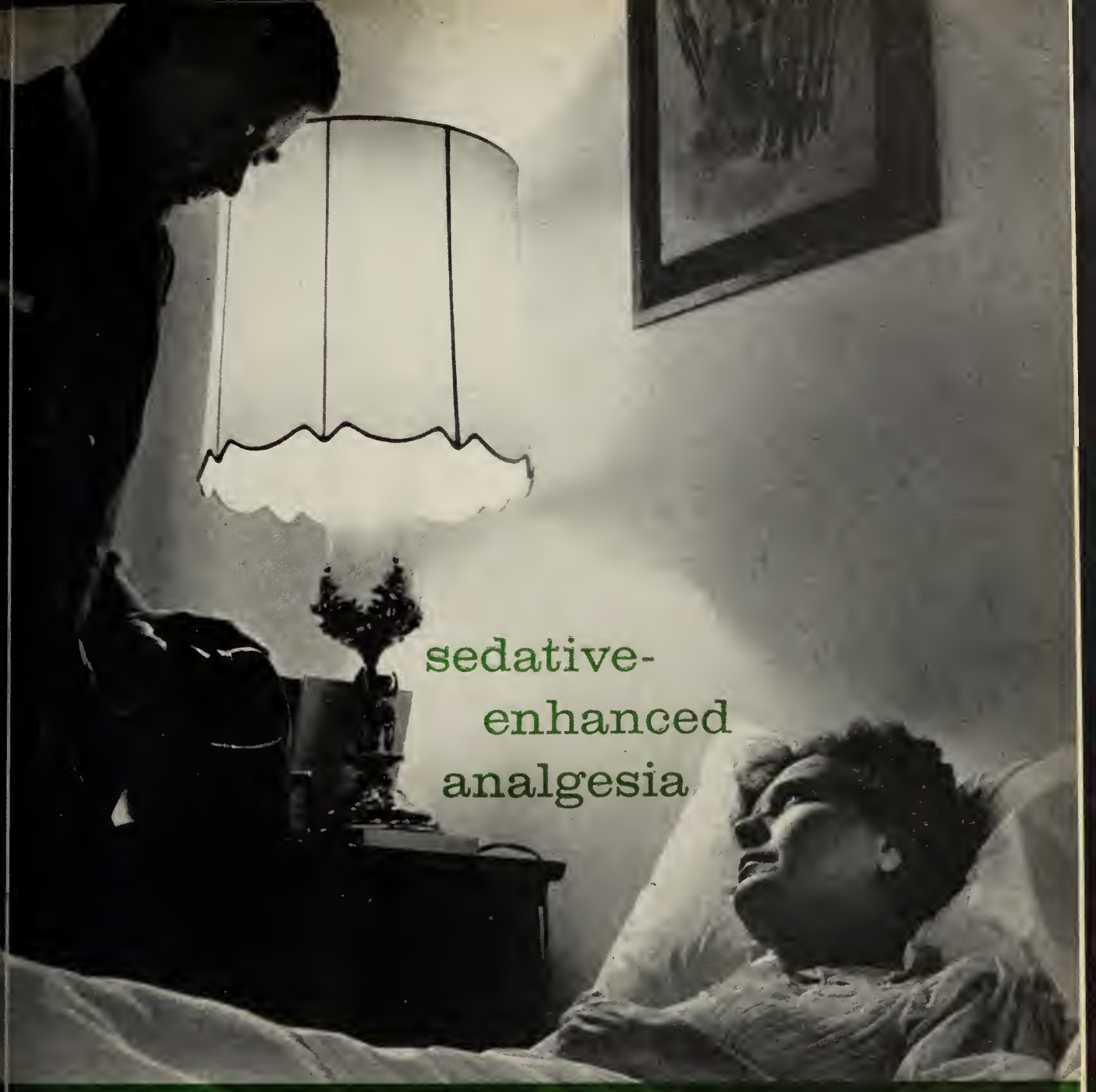
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*References:* (1) Root, H. F., and Bradley, R. F., in Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 10, Philadelphia, Lea & Febiger, 1959, pp. 411, 437. (2) Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: *ibid.*, pp. 188-189. (3) Marks, H. H., *et al.:* Diabetes 9:500, 1960. (4) Marble, A., in Summary of Conference on Diabetic Retinopathy, Survey Ophth. (Part 2) 6:611-612, 1961.

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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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1. Borota, A., and Grinell, R. N.: J. Amer. Geriatrics Soc., 10:413, 1962.
2. Spoor, H. J.: N. Y. State J. M. 58:3292, 1958.
3. Lubowe, I. I.: Western Med. 1:45, 1960.
4. Weissberg, G.: Clin. Med. 7:1161, 1960.

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**Disturbances Of Heart Rate, Rhythm, and Conduction,** by Eliot Corday, M. D., and David W. Irving, M. D. ($8.50, *W. B. Saunders Company, Philadelphia 5, Pa.)* This excellent little book is written for medical students and clinicians and makes no pretense of dealing with the various arrhythmias exhaustively. It does fulfill the authors' stated purpose of providing a physiological foundation for the understanding of disturbances of heart rate, rhythm, and conduction.

It is clearly written and profusely illustrated with excellent diagrams. For those desiring more detailed information, the four hundred and sixty-seven references should be adequate.

Very little is said about the newer use of such electrical gadgets as pacemakers and defibrillators, but this is no great deficiency in a book of this sort.

The text is highly recommended for practicing physicians.

**Hypertension — Recent Advances,** The Second Hahnemann Symposium on Hypertensive Disease edited by Albert N. Brest, M. D., and John H. Moyer, M. D. ($12.00, *Lea & Febiger, Philadelphia 6, Pa.)* A symposium including contributions from 117 authorities, this text contains a wealth of information regarding recent developments in a rapidly changing field. In general, the papers are well done. Although the list of participants includes many outstanding people, one searches in vain for the comments of many other widely recognized authorities in this field, who are not included in the symposium.

**Frontiers in General Hospital Psychiatry,** by Louis Linn, M. D. ($10.00, *International Universities Press, New York 11, N. Y.)* Increasingly the emphasis on the similarities of the needs of sick people, whether they are physically or mentally ill, is leading to the increasing provision of care and treatment of psychiatric disorders in general hospitals. Dr. Linn has produced a survey of the problems of general hospital treatment which is particularly timely and useful. General medicine should become more conscious of psychiatric thought, just as psychiatry can benefit greatly from closer contact with general physicians.

**The Human Adrenal Gland,** by Louis Julius Soffer, M. D., Ralph I. Dorfman, Ph. D., and J. Lester Gabrilove, M. D. ($18.50, *Lea & Febiger, Philadelphia 6, Pa.)* Nowhere else in medicine have chemists and clinicians combined their efforts to such advantage as in the study of the 10 grams of tissue represented by the normal adrenal glands. The bulk of our knowledge of these glands has been accumulated in the past few years, and this text admirably summarizes current thinking.

**A Manual of Cutaneous Medicine,** by Donald M. Pillsbury, M. D., Walter B. Shelley, M. D., and Albert M. Kligman, M. D. ($9.50, *W. B. Saunders Company, Philadelphia 5, Pa.)*

**Textbook of Medical Treatment,** by Sir Derrick Dunlop, M. D., Sir Stanley Davidson, M. D., and S. Alstead, M. D. ($12.50, Eighth edition, *The Williams & Wilkins Company, Baltimore 2, Md.,* exclusive U. S. agents.)

**Psychophysiological Aspects of Space Flight,** by Bernard E. Flaherty, Lt. Col., USAF (MC). ($10.00, *Columbia University Press, New York 27, New York.)*

**Aerospace Medicine,** by Major General Harry G. Armstrong, USAF (Ret.) and 21 contributing authors. ($18.00, *The Williams & Wilkins Company, Baltimore 2, Maryland.)*

**Human Factors in Jet and Space Travel,** by S. B. Sells, Ph. D., Charles A. Berry, M. D., and foreword by Oliver K. Niess, M. D. ($12.00, *Ronald Press Company, New York 10, N. Y.)*

**The Putnam Medical Dictionary,** by Norman Burke Taylor, M. D., and Allen Ellsworth Taylor, D. S. O., with the assistance of Ann D. A. Taylor, B. A. ($4.95, *G. P. Putnam's Sons, New York 16, New York.)*

**Year Book of Pediatrics; 1961-1962 Series,** by Sydney S. Gellis, M. D. ($8.00, *Year Book Medical Publishers, Inc., Chicago 11, Illinois.)*

**A History of Medicine,** by Henry E. Sigerist. ($11.00, volume 2, *Oxford University Press, New York 16, New York.)*

**Circulatory Ulcers,** by Hilton G. Tranchell and Charles R. Bannister. ($3.50, *The Williams & Wilkins Company, Baltimore 2, Md.,* exclusive U. S. agents.)

**Birth Injuries of the Newborn,** by Philip Schwartz, M. D., foreword by Sir Eardley Holland. ($19.50, *Hafner Publishing Company, New York 3, N. Y.)*

**Biological Activity of the Leucocyte:** Ciba Foundation Study Group No. 10, by G. E. W. Wolstenholme, O. B. E., and Maeve O'Connor, B. A. ($2.50, *Little, Brown and Company, Boston 6, Mass.)*




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| Brown Gravy | 1 tbsp. | 7 | 21 |
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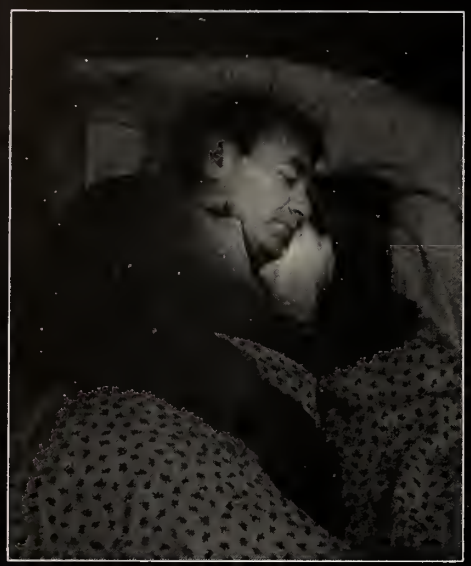
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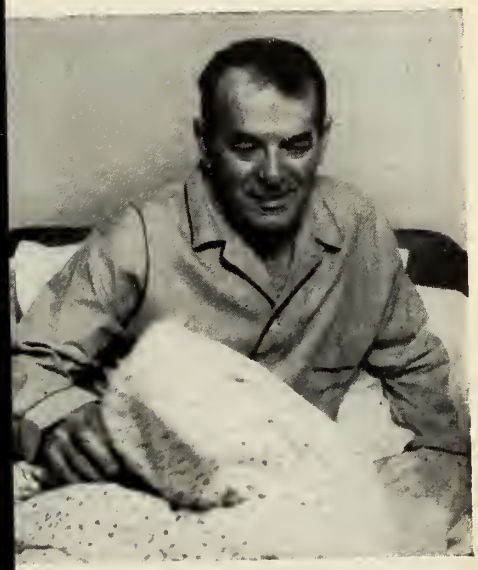


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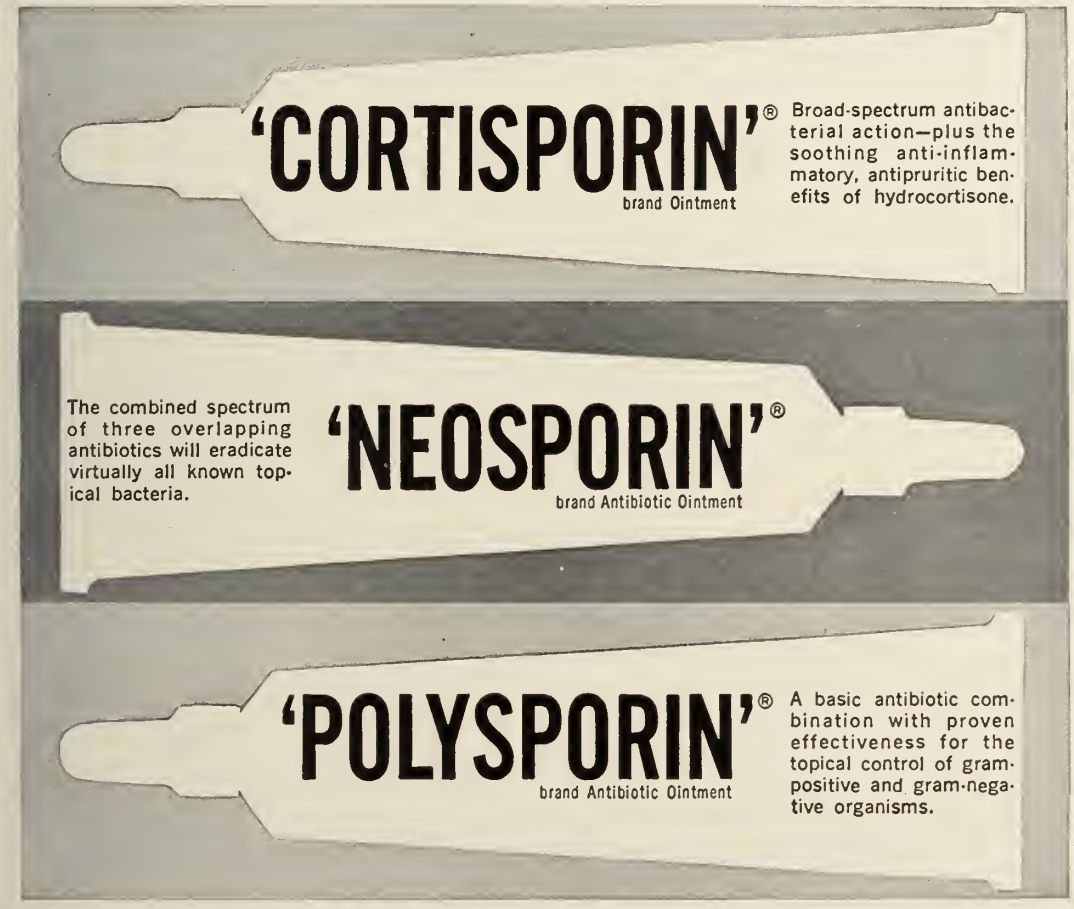
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Salutensin combines Saluron® (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide[9]; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

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**Each Salutensin tablet contains:** 50 mg. Saluron® (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

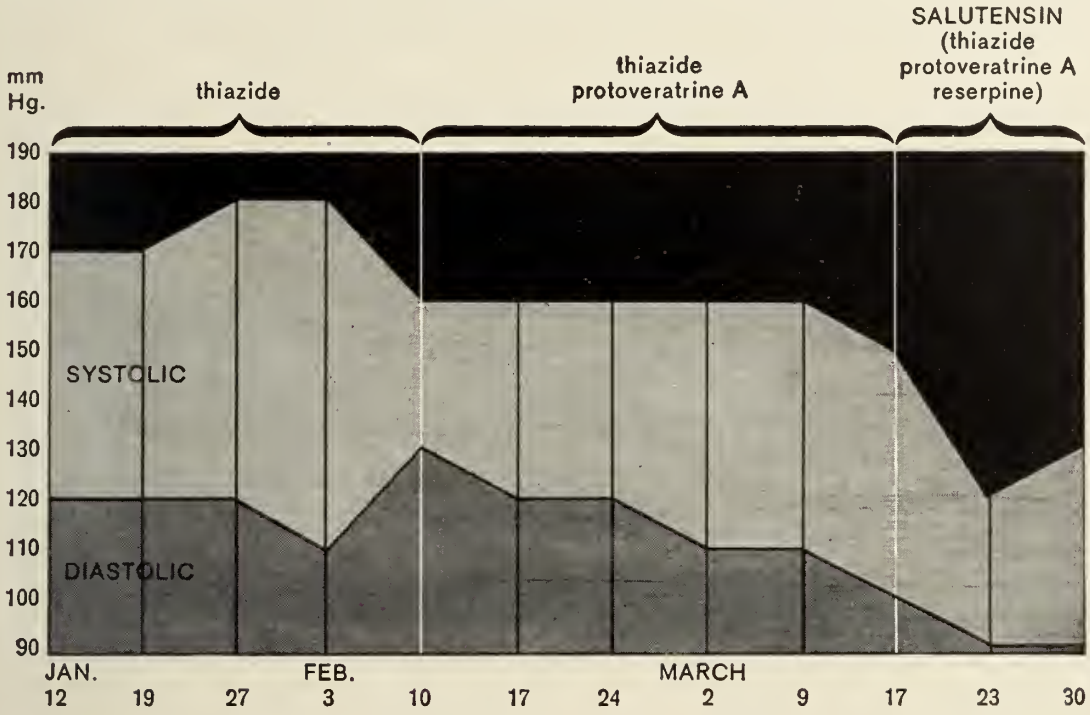
**Supplied:** Bottles of 60 scored tablets.

**References:** 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

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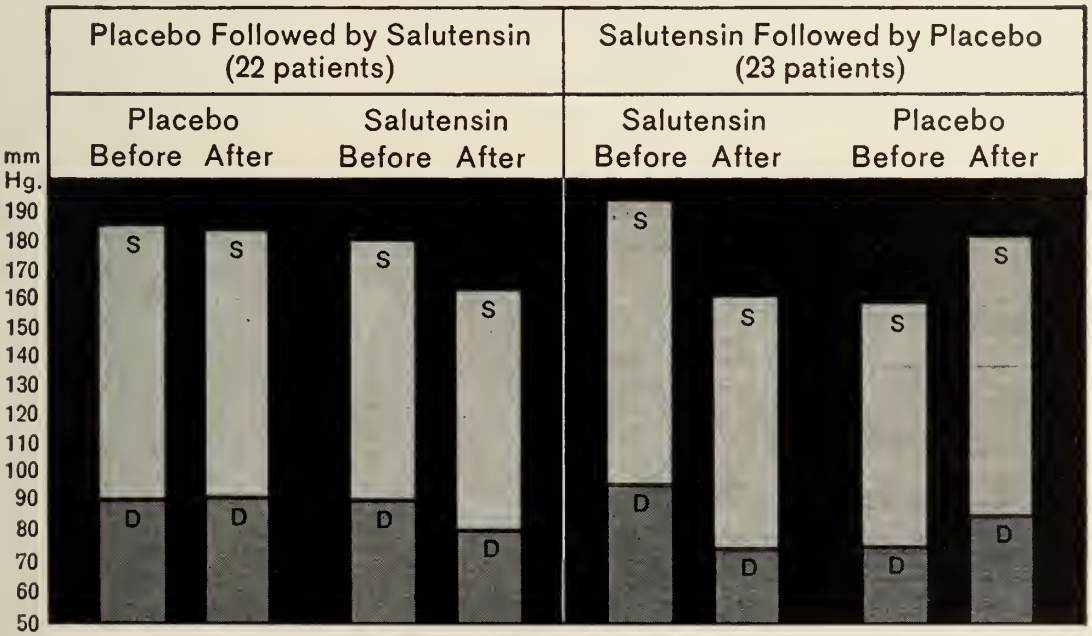
**11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE**

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



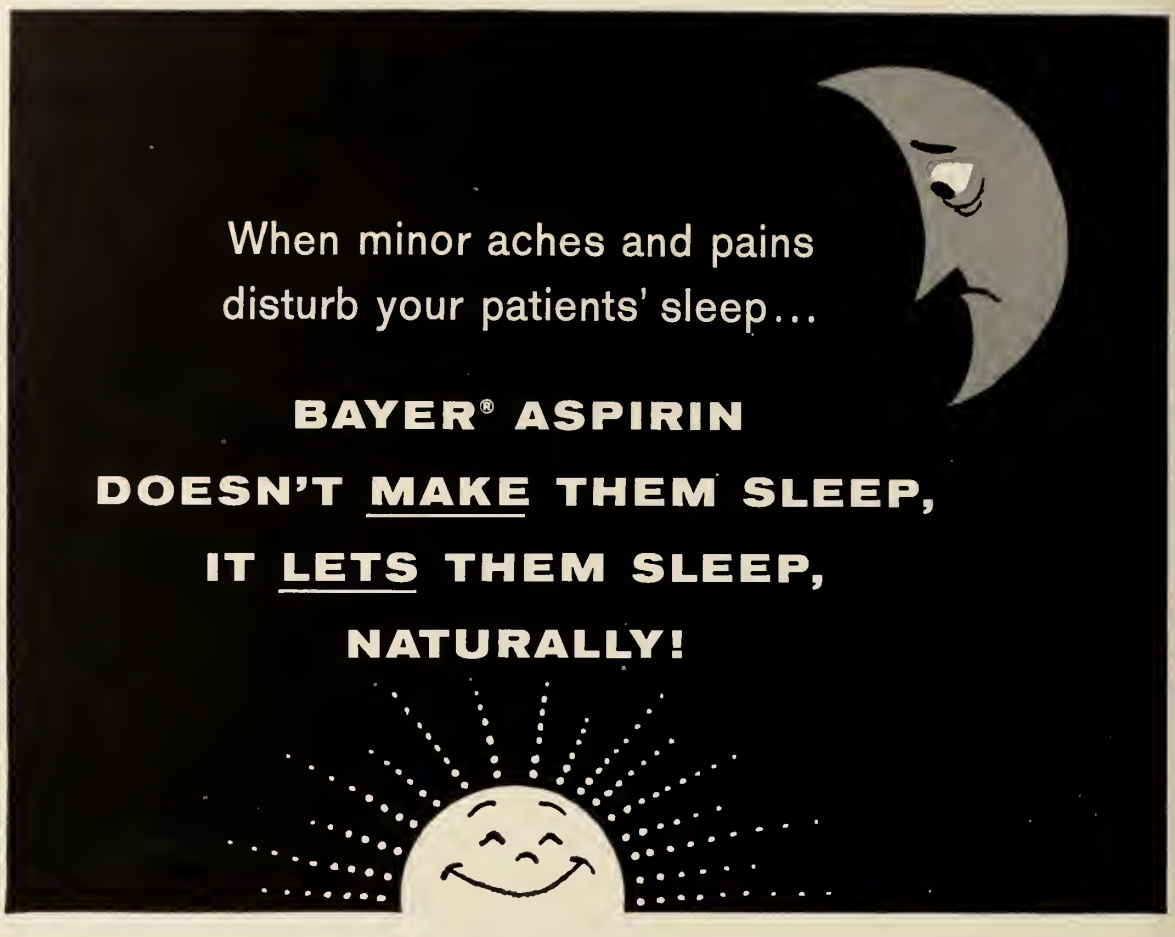

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Mean Blood Pressures–Systolic (S) and Diastolic (D)




In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

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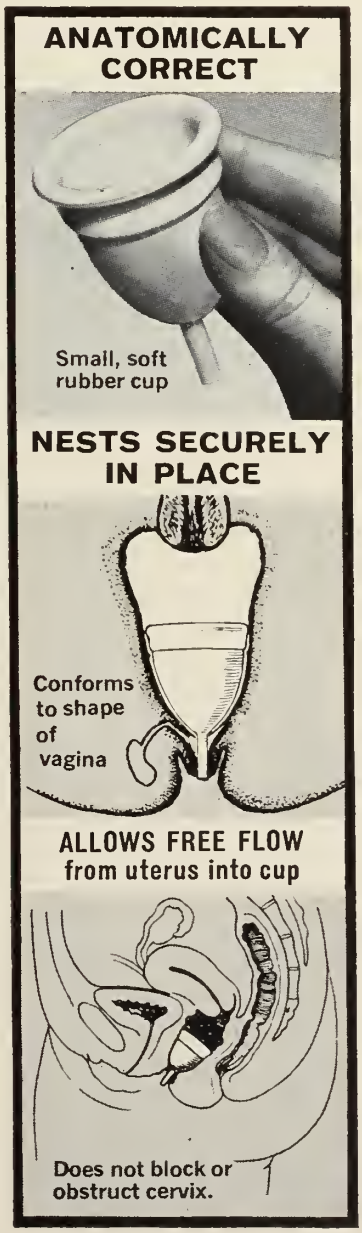
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Ref.: Karnaky, K. J., Tri-State Med. J., Sept. 1961. Burrus, S. Jr., Am. J. Obst. & Gynec., Aug, 1960. Karnaky, K. J., Tri-State Med. J., June, 1960. Schaefer, G., Clin. Obst. & Gynec., June, 1959. Liswood, R., Obst. & Gynec., May, 1959.

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1. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No. 2, February, 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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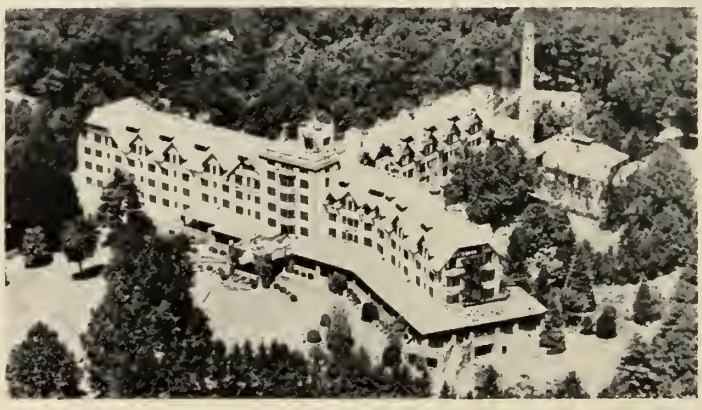
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| Location | Facility | Telephone |
|---|---|---|
| Akron | Children's Hospital<br>W. Bowery and W. Bechtel | BL 3-5531, Ext. 246 |
| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
| Toledo | Toledo Health Department<br>635 N. Erie St. | CH 4-1961—(Day)<br>EV 5-4661—(Night) |
| Youngstown | Emergency Room Dept.<br>St. Elizabeth Hospital<br>1044 Belmont Street | RI 6-7231, Ext. 220 |


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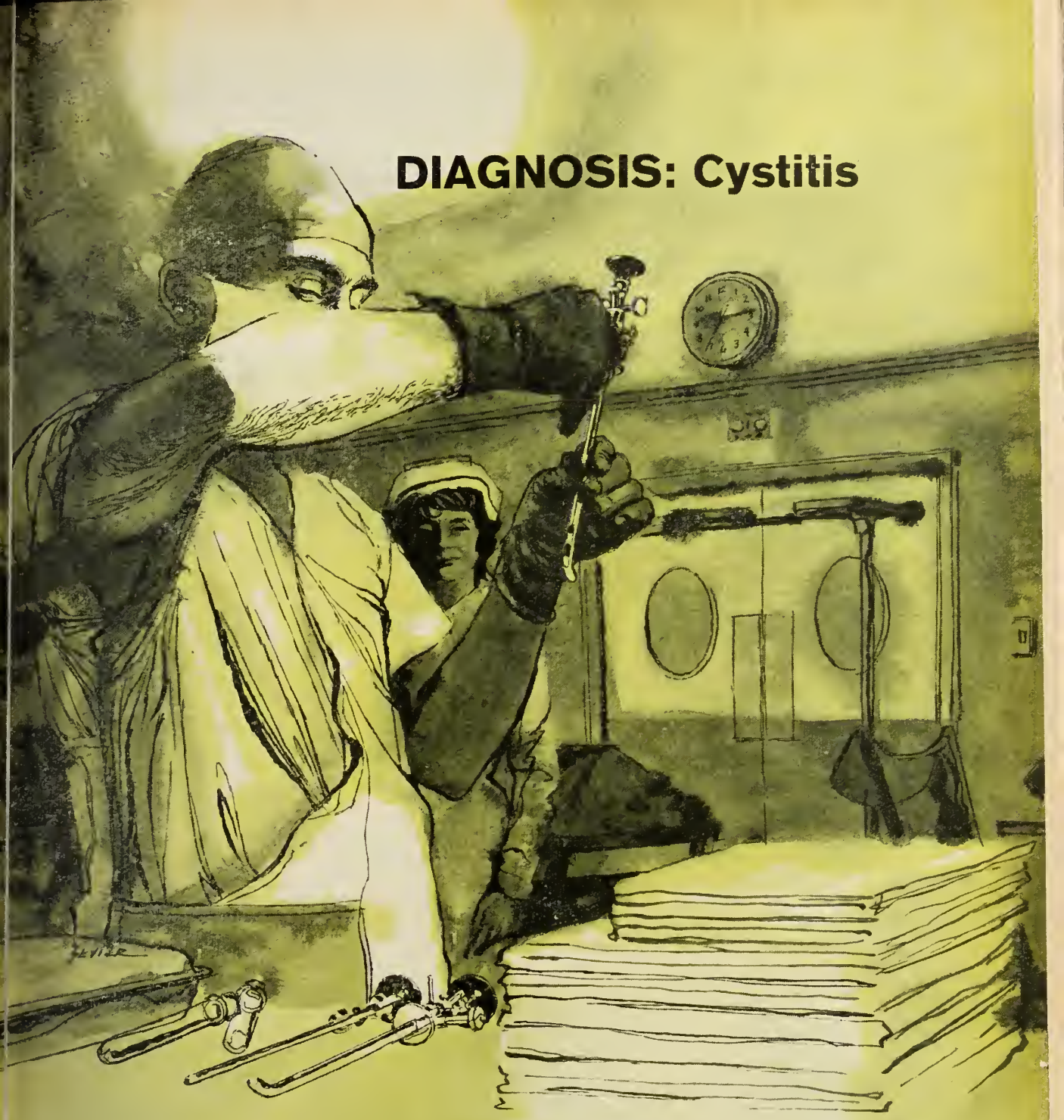
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The Historian's Notebook

# History of the Lakeside Unit Of World War I

HARRY D. PIERCY, M.D.*

## Part III

*(Continued from June Issue)*

ARRIVING at General Hospital No. 9 we found the wards or huts filled with sick and wounded and the hospital staffed with British Medical Officers and Nurses, called Sisters and British V. A. D.s. There was also a full complement of Tommies who were ward orderlies and stretcher bearers. Base Hospital No. 4 gradually took over these wards and in a few days the British personnel, with the exception of the V. A. D.s, departed. Also left with us were Major F. E. Withers, R. A. M. C., registrar for the British patients, and Captain F. J. Filmer, R. A. M. C., Quartermaster, who had under his command 20 or more Tommies who looked after the policing of the camp and the gardening about the Administration Building, the officers' mess hall and nurses' quarters. The camp at all times wore a trim and neat appearance. Graveled paths were at right angles and connected the officers' quarters with the officers' mess hall. This enclosed a quadrangle open toward the route d' Elbouf which ran in front of our hospital.

### A Flagpole Is Erected

Our first project was to erect a flagpole in front of the Administration Building. A lofty straight pine was selected from the nearby forest, trimmed and topped and provided with a crossarm or halyard from which was hung the American flag, the British flag and the Red Cross flag.

The hospital had a bed capacity of about 1200 which could be increased to 1750.

Our patients, with the exception of a few Americans who were serving in the British sector, were English, Scottish, Welsh, Irish, Canadian, Australian, New Zealand, and South African. It was a broadening experience to be brought into close and intimate contact with men of these nationalities, with their characteristic dialects and widely differing social and cultural backgrounds. It took but little time to break through the barriers of our then provincial U. S. A. life when suddenly we were brought in touch with English speaking people from far-away places. Shortly we were aware of common human factors and we quickly appreciated and understood the staunch, sturdy, and enduring qualities of these people with whom many of us must have had common, though remote, ancestors.

### The "Owl Parade"

The patients were brought to us in British ambulances, four stretchers to the car. The lightly wounded and the "walking sick" would be brought sitting up in a small bus containing perhaps 20. The latter would be paraded and examined the next morning by two or three medical officers and be marked for distribution to convalescent camp (C.C.), retained for a day or so, or sent to special hospitals. Occasionally one or more would be given a "Blighty," i. e. sent to England. Because these patients arrived during the night, the examining officers called this procedure the "owl parade." This was held immediately after breakfast, and there would be 20 to 60 "owls" in this procession. They came in stripped to the waist and, after a little experience, the examination of the average patient required only a few minutes. Our findings were recorded on his service record which he carried with him. A sergeant did other necessary paper work.

### British C. C. S.

About the end of the first week a surgical team was sent up to the British Casualty Clearing Station (C. C. S.). This included Dr. Crile, Dr. Lower and Dr. Charles F. Hoover, as well as two surgeons, operating room nurses, anesthetists and orderlies. The C. C. S. was close to the line and frequently was under shell fire and subjected to bombing by airplanes. The work was very heavy and the selection of patients for operation depended upon sharp and keen clinical judgment.

### Sea Water Infusions

Our group was shocked by the so-called "Moratorium Ward" where the presumably fatally gassed

*Dr. Piercy, Cleveland, is a member of the courtesy staffs of University Hospitals, and St. Luke's Hospital, Cleveland, Ohio.

Submitted June 23, 1961.



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or wounded were placed to die without further professional attention. At Dr. Crile's insistence this ward was renamed the "Resuscitation Ward" and was placed in charge of a team skilled in the methods of resuscitation. There was an urgent need for blood transfusions but no means at hand to give these treatments. Sea water being practically identical with the fluids of the body, Dr. Crile and Dr. Hoover decided to try sea water as an intravenous infusion. They obtained sea water from a quarter of a mile out in the bay and mixing this with sterile water 1 to 3, they had the satisfaction of seeing the highly toxic wounded regain consciousness and become afebrile after several sea water infusions. Some patients recovered sufficiently to submit to necessary surgery.

### Blood Transfusions

The sea water treatments were not long continued. When blood transfusions were made convenient and practical, they proved to be much more efficient. In a few days Dr. Crile went to Paris and at Gentile's he found a glass blower who could make some Vincent tubes. These were renamed "No. 17" after the C. C. S. at Rémy Siding where he and Major Lower introduced blood transfusions to the British line. The Vincent tubes were distributed among the Casualty Clearing Stations and of course a plentiful supply was left at No. 9 Hospital. During the first year 320 blood transfusions were given by our unit.

No. 9 General Hospital was a busy place, convoys in and convoys out. Many of the wounded and the ill came from the muddy trenches and terrain of Flanders. I remember one mud encased Scottie whose kilt weighed 12 pounds and which, when removed, stood up unsupported. I ask you to imagine, if you can, the hard work of the nurses and the orderlies who took these patients fresh from the trenches and got them out of their blood and mud soaked clothes, bathed and dressed and put between clean white sheets.

### Nitrous-Oxide Plant

Our supply of nitrous-oxide was running low. In the presence of a constantly growing demand for this type of anesthesia in many British hospitals, and the uncertainty of receiving shipments of the gas from America, it was necessary to arrange for its local manufacture. On June 29, 1917, Dr. Crile made arrangements with the head of the Red Cross to construct a nitrous-oxide plant in Paris.

Some convoys consisted of the victims of shot and shell. These had been treated and held from one to five or more days at the C. C. S., and would receive further surgical treatment in our hospital. There were convoys of sick and convoys of gassed cases. The gasses used were chlorine, mustard gas, and phosgene. Mustard gas was a vesicant causing serious pulmonary reaction and huge blisters when applied to the skin. It was heavy and would cling to the ground. Troops falling out for rest on a grassy bank would be surprised in a few hours by the occurrence of small to huge blisters over the portions of the body having contact with the contaminated ground. This meant serious and prolonged disability.

### Trench Fever

Trench fever, known for long as P. U. O. (pyrexia of unknown origin), was the cause of the greatest morbidity in the troops of the belligerents. From 1915 to 1918 it was the cause of from one third to one fifth of all illness in the British army in France, and one fifth of all diseases in the German and Austrian armies. In 1918 it was proven to be a louse-borne disease. The virus was present in the blood and urine. There was usually an enlargement of the spleen and an erythemia consisting of small flat pick spots. In the febrile stage the temperature would rise to 103° to 104°F. The symptoms were pain back of the eyeballs, headache and pains in the back and legs. The incubation period was from 12 to 30 days. Disability in the individual patient varied from two to six weeks but certain patients had relapses over a period of a year. There were no fatalities.

During 12 months of service the hospital cared for 82,179 patients. There were 538 deaths among which were 45 Americans.

### Mobile Hospital No. 5

Mobile Hospital No. 5 was organized late in August 1918 to assist in the American sector. It was under the command of Colonel John B. Corser; six officers, 20 nurses, and 35 enlisted men were taken from General Hospital No. 9. On location it was reinforced with medical officers and men from the British Expeditionary Force, bringing the staff up to 12 officers and 85 enlisted men. The hospital was located in an old French barracks in the Bois de les Placys, five miles from the Argonne front. It was in a woody ravine thoroughly camouflaged with leafy branches. There was a very active service under most difficult conditions, complicated by constant rain and deep mud. The command moved about on duck boards and almost everyone, men and nurses, wore boots. Rats were numerous and contested the right of way on the duck boards.

The hospital received patients starting September 25 and from that date 994 were received. These were the seriously wounded soldiers of all ranks from the American, French and German armies. There were 135 deaths. A small area on a hillside was marked out for a cemetery and these dead were buried there in graves dug by German prisoners who seemed to enjoy this duty. The American personnel of the Mobile Hospital returned to No. 9 on January 12, 1919.

*(To Be Continued in August Issue)*

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—Gray, H. R., Wolf, R. L., and Doneff, R. H.: Evaluation of Flurandrenolone, a New Topical Corticosteroid, Arch. Dermat., *84:*18, 1961.

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VOL. 58 JULY, 1962 NO. 7

# Adjunctive Use of Prozine in Somatic Illness

## A Controlled Study

WILLIAM F. BRADLEY, M.D.

THE rationale for using a combination of meprobamate and promazine to attack the psychosomatic component of organic illness has been presented by others.[1,2,4] In discussing their approach to the problem, they have pointed out that these compounds have different sites of action in the central nervous system. Experimentally, it has been shown that meprobamate acts within the thalamus, blocking interneuronal pathways, while promazine suppresses impulses to the hypothalamic region of the diencephalon. This may be why meprobamate primarily influences emotional responses, while promazine chiefly modifies thought patterns. Since thoughts and feelings are inextricably involved in psychological stress, it would seem reasonable to expect a more complete tranquility to result from the combined use of these substances.

Parks[1] used Prozine®* in 89 office patients with a variety of somatic disorders and noted a dual and synergistic action which simplified the management of psychogenic symptoms, 92 per cent of his patients being completely relieved from emotional tension. Oswald[2] employed the same preparation in 100 ambulatory patients and reported that all psychological stress was eliminated in 70 per cent, with a good effect in an additional 15 per cent. Horwitz[3] found that the combination controlled disease-induced anxiety in 94 per cent of 47 patients, most of whom were suffering chronic, long-term organic illnesses. More recently, Splitter[4] treated 69 office patients with a variety of physical diagnoses, and claimed that in 94 per cent the psychosomatic symptom complex was completely or nearly abolished.

These investigations, however, incorporated small numbers of patients and were not controlled. Horwitz[3] used a placebo group, but not in a standardized way. It was felt that there is a need for a double blind, adequately controlled study to verify their findings.

Three of these investigators encountered frequent drowsiness.[2-4] Although Horwitz felt that the drowsiness might be explained on the basis of the poor physical condition of his patients, and suggested that the dosage of Prozine be halved whenever this occurs,[3] the symptom may be just a reflection of the

From the Central Ohio Medical Clinic, Columbus, Ohio. Submitted September 8, 1961.

*Prozine® (meprobamate and promazine hydrochloride) available from Wyeth Laboratories.

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fatigue which results from constant anxiety and tension but is noticed only when these are relieved. Oswald[2] considered it an index of effectiveness. It most often appears during the 48 hour period after medication has begun, and often moderates or disappears later on.

Since my first use of the full-strength Prozine capsules was attended by a similarly high incidence of initial drowsiness, it was decided that the present study should have a double objective: to test the efficacy of Prozine in a controlled experiment, and to determine if halving the dose would eliminate persistent drowsiness while still permitting adequate control of psychological stress.

## Design and Method

The subjects were selected from the ambulatory clinic and private office patients of a general internal medical practice. Every subject had severe underlying difficulties, almost always with an organic basis, and a superimposed psychological stress manifested as anxiety, tension or apprehension. A total of 97 were treated, and were divided into two groups: Prozine (47) and placebo (50). Three patients in the original Prozine group discontinued therapy during the course of the 12-week study, and were dropped from it, making the two groups unequal in size.

The Prozine group included 14 men and 33 women, whose ages ranged from 30 to over 65 years (three over 65), with the mean age of those in the 30 to 65 year old group being 47 years. The placebo group consisted of 20 men and 30 women, whose ages ranged from less than 30 to over 65 years (eight being over 65 and one under 30 years), with the mean age of those 30 to 65 being 49 years.

TABLE 1. *Primary Disorders of Patients in Controlled Prozine Study*

| Diagnoses | Placebo | Prozine |
|---|---|---|
| Hypertensive Cardiovascular Disease | 13 | 13 |
| Osteoarthritis | 6 | 1 |
| Anxiety Reaction, Severe | 10 | 6 |
| Diabetes Mellitus | 3 | 2 |
| Myofascitis | 6 | 1 |
| Tachycardia, Paroxysmal | 2 | 2 |
| Headache (Including Migraine) | 2 | 2 |
| Thyrotoxicosis | 1 | 1 |
| Emotional Problems, Severe | 1 | 3 |
| Psychophysiologic G. I. Reaction | 2 | 2 |
| Coronary Insufficiency | 1 | 1 |
| Duodenal Ulcer | 2 | 3 |
| Obesity, Exogenous | 1 | 2 |
| Cholecystitis, Cholelithiasis | 3 | 2 |
| Diverticulosis | 2 | 1 |
| Globus Hystericus | 1 | 1 |
| Arteriosclerosis | 3 | 2 |

*In addition,* the following disorders were found in one group only:

**Placebo:** Arrested tuberculosis, trauma (car accident), pituitary adenoma, narcotic addiction, exhaustion, chronic glomerulonephritis (2), cirrhosis, pancreatitis (2), protruded nucleus pulposus (3), retinal hemorrhages, ovarian insufficiency (2), muscular tension, rheumatic endocarditis (healed), carcinoma of thyroid, hypoparathyroidism, goiter, "psychogenic" rheumatism, Stokes-Adams syndrome, duodenitis, ileitis, and hiatus hernia.

**Prozine:** Spontaneous abortions, congenital malformations, hypothyroidism (4), pyelonephritis, recovery from surgery, tinea versicolor, uterine fibroids, nausea and vomiting of pregnancy, presurgical stress, malnutrition, severe psychoneurosis, epistaxis, ulcerative colitis, epilepsy (grand mal), hypogonadism (2), pulmonary emphysema, paralysis agitans, thromboangiitis obliterans (Buerger's Disease).

When patients were first seen, histories were taken, including an "emotional evolution" (which attempted to uncover possible causes of stress), and the average number of hours per night spent in sleeping. Blood pressure, weight, pulse rate and other data were obtained. The patient's primary disorder was then diagnosed and recorded. The presenting difficulties are listed in Table 1. Although some patients exhibited a complex clinical picture, the two groups contained about equal numbers of patients with inflammatory, neoplastic, degenerative, metabolic and congenital diseases, and had an approximately equal representation in the various physiological systems. Three patients in the placebo group, and 5 in the Prozine group, had no demonstrable organic lesion, but were suffering from functional derangements.

Treatments were first prescribed for the underlying disorders and were quite varied. For both groups, conventional agents and regimens were utilized as indicated. These included hypotensive agents, diuretics, cardiotonics, anticonvulsants, hormones, metabolic agents, gastrointestinal tonics, antihistaminics, central nervous system stimulants, antifungals, antispasmodics, anticoagulants, antacids, insulin, antiarrhythmics, special diets, sedatives, anticholinergics, analgesics, vasodilators, and prescriptions of unknown medications which had been given by referring physicians.

Standard, full-strength tablets of Prozine were administered, containing 200 mg. meprobamate and 25 mg. promazine hydrochloride, with placebos identical in physical characteristics for the other group. In the Prozine group, 27 patients were started on one tablet three times daily; while in the placebo group, 37 had this initial dosage. Most other patients were started on one tablet twice a day. In the placebo group, one diabetic patient was started on a half tablet two times daily (which sufficed). In the Prozine group, one patient with essential hypertension received the half tablet three times a day, and one patient with a congenital malformation of the hand and foot was given a full tablet once a day.

After the administration of 50 full-strength tablets (in most cases at the end of two weeks), patients were re-examined. Subjective responses of "calmer" or of "no effect" were elicited which were, if possible, confirmed by observation. Note was also made of any side effects which had appeared. Any changes in sleeping time, blood pressure, weight or pulse rate were recorded. Although many patients experienced some transient drowsiness when starting therapy, if drowsiness was still a problem at this point, the dosage was reduced to the half tablet, which was administered the same number of times each day as had been the whole tablet. Final examinations were made at the end of the 12-week period, and the same information was again obtained and recorded. Spe-

cial attention was paid to whether those patients on reduced dosage were still experiencing drowsiness and whether they were still calmer.

This study did not encompass the many patients who had previously received multiple trials of medication on a double-blind basis, using Prozine in a capsule form. The essential finding in these patients had been that the medication was a potent calmative but that in too many cases it produced drowsiness. Half-strength capsules had later been tried, and the results with these had encouraged the setting up of a formal, controlled study, using a scored tablet instead of the capsule form. Because some gastric distress had been observed, six patients had previously been given known amounts of Prozine and then had been examined gastroscopically; but no abnormalities were found which implicated meprobamate or promazine.

## Results

Table 2 compares responses of the two groups. The desired therapeutic effect was obtained with a much higher frequency with Prozine, 74 per cent of the patients in this group being calmer compared with only 18 per cent in the placebo group. The difference was statistically significant, since it would occur by chance less than one time in a thousand (chi-square test). The occurrence of a calmative effect in 18 per cent of those in the placebo group is well within the usual expectations of "placebo reactors."

Eight patients in the Prozine group, and five in the placebo group, were not only calmer but were too drowsy. For these patients the dosage was halved, by administering a half tablet in place of the whole one. In the Prozine group, six of the eight (75 per cent) reported that this resulted in disappearance of drowsiness without loss of the desired calmness. In the placebo group, only one of the five patients (20 per cent) had a similar result.

There were no significant differences in the blood pressure, weight or pulse rate changes between the two groups. Both groups had an initial mean systolic pressure of approximately 140 mm. Hg. After 50 tablets had been taken, this rose to 146 in the Prozine group, but showed no change in the placebo group. This is somewhat remarkable in view of the fact that a hypotensive effect is sometimes expected from any phenothiazine derivative. At the end of the 12-week period, both groups had returned to the original systolic pressure. Diastolic pressures showed comparable fluctuations, but at the end did not quite return to the pretherapy levels. Weights and pulse rates before and after therapy showed little or no change.

TABLE 2. *Therapeutic Responses in Prozine and Placebo Groups*

| *Chi-square* Group | Number in Group | *No Effect* Observed | *No Effect* Expected | *Calmer* Observed | *Calmer* Expected |
|---|---|---|---|---|---|
| Placebo | 50 | 41 | 27 | 9 | 23 |
| Prozine | 47 | 12 | 26 | 35 | 21 |
| Totals | 97 | 53 | | 44 | |

*Calculations*

50/97 X 53 = 27 47/97 X 53 = 26

50/97 X 44 = 23 47/97 X 44 = 21

$$\chi^2 = \sum \frac{(\text{Observed} - \text{Expected})^2}{\text{Expected}} = \frac{(41-27)^2}{27} + \frac{(12-26)^2}{26} + \frac{(9-23)^2}{23} + \frac{(35-21)^2}{21}$$

$$\chi^2 = 7.3 + 7.5 + 8.5 + 9.3 = 32.6 \text{ (1 degree of freedom)}$$

$P < .001$

Other mildly troublesome side actions were evident in one patient in the placebo group and four in the Prozine group. A total of 16 patients in the placebo group thus experienced untoward effects, compared to 18 patients in the Prozine group, the difference not being statistically significant.

In five patients in the Prozine group with side effects other than drowsiness (two with nausea, and one each with weakness, insomnia complicated with pruritus ani, and "dry throat"), reducing the dosage to the half tablet had no effect. In the placebo group, similar reduction had no effect on one patient with headache or on two patients who had, in addition to drowsiness (which was eliminated), agitation (in one) and insomnia (in the other).

## Discussion

There was no correlation between hypertensive cardiovascular disorders and the appearance of gastric distress in this study. Only one patient in each group

who had essential hypertension showed this effect. In addition, two in the placebo group with paroxysmal tachycardia had some distress.

If the optimum period is considered to be seven to eight hours, there was considerable improvement in the sleeping time of those treated with Prozine. Before starting therapy, a base sleeping time was established for all patients, and this was then used to measure changes induced by the medications. During the study, a definite shift occurred in the direction of more hours of sleep per night for those taking Prozine. For example, while only 44 per cent of all patients had slept seven or more hours each night before beginning therapy, after two weeks on Prozine 67 per cent of the patients obtained this number of hours of sleep.

Although this study was not designed to observe the effect Prozine might have on the course of the underlying organic disorders, and no data related to this are available, it is my impression that therapy for these has been made easier through improved patient cooperation. Diagnostic procedures have also been facilitated. Formerly, it was often difficult to differentiate between symptoms being produced by the organic lesion and subjective complaints arising from anxiety. Any agent which tends to separate these can be truly regarded as a valuable diagnostic tool.

## Summary and Conclusions

Ninety-seven general internal medical practice patients with anxiety, tension or apprehension superimposed on one or more primary organic disorders were divided into two groups and administered either Prozine or a placebo, usually one tablet two or three times daily. Treatment continued 12 weeks; but if drowsiness occurred, the dosage was reduced to a half tablet. On the whole-tablet regimen, 74 per cent of 47 Prozine-treated patients were calmer, compared to 18 per cent of those in the control group. However, 17 per cent of the patients in the Prozine group were also drowsy, compared with 10 per cent of the placebo group. After the dosage was reduced, 75 per cent of those taking the half tablet of Prozine remained calmer but had lost their drowsiness, while only 20 per cent of the placebo group experienced such a result. Other side effects were few and not significantly different in frequency of occurrence in the two groups. More patients in the Prozine group slept longer than in the control group.

For general use in internal medicine, Prozine appears to be a safe and dependable calmative preparation. It should have wide application for the relief of the psychological stress complicating the clinical picture in most organic disorders, thereby aiding diagnosis and therapy. It is free of serious side effects, and the incidence of minor adverse effects during its use is not significantly higher than can be seen in a control group. The drowsiness it sometimes produces can be eliminated in most cases by reduction of dosage without loss of the calming effect.

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ORAL FAT TOLERANCE as determined by the 9-hour postprandial serum optical density is a simple, practical, and efficient tool for screening large populations for abnormalities of lipid metabolism.

The study was conducted in 10 controls (young men) and in 13 young men with coronary heart disease and no prior history of hypertension, diabetes, myxedema, or chronic glomerulonephritis. Preprandial serum lipids were elevated in 12 of these 13 men. In the oral fat loading test, serum fatty acids in the experimental group with coronary heart disease did not return to preprandial levels for at least three hours. While the men were deprived of food over a 24-hour period, serum fatty acids and B-lipoproteins rose in the experimental group at a time that they continued to decrease in the control group. At nine hours, the serum optical density of the experimental group was more than twice the fasting level; this was significantly different from the density of the control group, which had returned to preprandial levels. Total fatty acids and cholesterol were always much higher in the coronary group.—ABSTRACT: Leonard J. Stutman, M. D.; Marilyn George, Lida G. Gottsch, et al., New York, N. Y.: *American Journal of Medical Science*, 242:736-745, (December) 1961.

# Megaloblastic Anemia Due To Primidone

## Case Report

ALFRED LUSTBERG, M.D., DOUGLAS GOLDMAN, M.D., and O. HERMAN DRESKIN, M.D.

MEGALOBLASTIC ANEMIA resulting from the administration of anticonvulsant drugs has been reported in the last six years with increasing frequency in European and American medical literature. A case of megaloblastic anemia due to diphenylhydantoin sodium (Dilantin®), occurring in a patient at Longview State Hospital, has been reported recently.[19] Since that report, we have had under observation another patient suffering from megaloblastic anemia associated with the use of primidone (Mysoline®). The following is the report of this case, including extensive laboratory documentation.

### Case Report

A 40 year old white woman was admitted initially to Longview State Hospital August 25, 1942. A diagnosis of neurosyphilis was supported by positive blood and spinal fluid serological tests for syphilis and Lange reaction 5554332100. She received extensive fever therapy, an arsenical (Aldarsone®), and bismuth and was discharged as improved on April 29, 1944.

In May 1945 she had her first convulsive seizure and was hospitalized in Birmingham, Alabama. She received penicillin therapy for 13 days. She was readmitted to Longview State Hospital June 7, 1945. She appeared dull, apathetic, and grossly psychotic. Spinal fluid Kolmer was 3 plus with Lange reaction 5554332100 and blood serologic tests for syphilis were positive. Treatment with diphenylhydantoin sodium 100 mg. three times a day was begun.

A careful record of medication is available only from 1952 onward. From 1952 to 1958 she received diphenylhydantoin 100 mg. three times daily. On March 10, 1958, because the patient's seizures were not relieved completely, primidone therapy was begun and diphenylhydantoin was gradually decreased, so that by May 12, 1958 the diphenylhydantoin had been discontinued and primidone was being given 0.25 Gm. three times a day. Seizures had become infrequent. On March 9, 1959 the primidone was increased to 0.25 Gm. four times a day. This practically eliminated convulsive episodes.

On June 1, 1959 she was observed to be pale and weak and to have pitting edema of the lower extremities. Her blood pressure was 140/60 and pulse rate 104. Her heart was enlarged and a grade 2 systolic murmur was audible. Digitoxin, tetracycline, amiophylline, and intramuscular mercurial therapy were started. The patient continued to receive primidone 0.25 Gm. four times a day. She was transferred to the hospital ward June 10, 1959. The laboratory findings are tabulated in Table 1.* On admission the hemoglobin was 4.0 Gm. per 100 ml. and the red blood cell count 1.7 million per cu. mm. The red blood cells were macrocytic. The bone marrow was megaloblastic (Fig. 1).

Initial therapy consisted of a transfusion of 500 cc. of blood which produced a moderate degree of immediate improvement. Primidone was discontinued on admission to the hospital ward. She became afebrile, and heart failure became compensated within the first 14 days, but the macrocytic anemia persisted unchanged. Primidone was resumed, 0.25 Gm. four times a day, and folic acid 0.25 mg. daily was started. Within three days the patient became weak and developed daily temperature elevations to 101.2°. Penicillin and streptomycin therapy were started at this point. On July 2, 1959 (21 days after admission) her condition deteriorated and it became necessary to give 500 cc. of whole blood. Primidone was discontinued again, but the folic acid, 0.25 mg. daily, was continued. A low grade fever and general weakness persisted. The macrocytic anemia was unchanged. Free hydrochloric acid was found to be present in the gastric secretion. On July 16, 1959 primidone was resumed, 14 days after having been discontinued, and folic acid was increased to 5 mg. twice a day. Within the next two weeks there was striking improvement in the patient's general well-being, the hemoglobin rose to 9 Gm., and the reticulocytes increased to 20 per cent. The serum iron decreased to below normal. Within the next four months the patient's laboratory findings returned to normal values. The patient was mentally alert although psychotic.

On November 11, 1959, five months after admission to the hospital ward, she was found sitting in her chair, dead. No autopsy was obtained.

### Discussion

Differentiation of drug induced megaloblastic anemia from classic Addisonian pernicious anemia can be made by the radioactive vitamin $B_{12}$ absorption test, the presence of hydrochloric acid in the stomach, serum vitamin $B_{12}$ levels, and the therapeutic response to vitamin $B_{12}$ and folic acid. In general, the drug induced states show free hydrochloric acid in


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Submitted August 29, 1961.

*Folic acid and $B_{12}$ determinations were performed by Dr. John Will at the Hematology Laboratory of the Cincinnati General Hospital.

the gastric secretion, normal mucosal biopsies, and normal cobalt-60 vitamin $B_{12}$ absorption studies. Response to vitamin $B_{12}$ therapy was noted in nine cases.[1,5,7,9,14,16,19] Response to folic acid occurred in 16 cases.[1,2,3,4,7,9,11,16]

Nutritional deficiency of folic acid or vitamin $B_{12}$ is always to be considered, particularly in psychotic individuals. The nutritional history, if obtainable, could be most important eliminating this possibility. Otherwise, as in the present case, one could administer a minimally effective dosage of the vitamin concurrently with the offending drug. In nutritional deficiency of folic acid, a reticulocyte response should occur. If a drug were blocking utilization of folic acid, there would be no reticulocytosis. Blood serm and urine levels of folic acid and $B_{12}$ provide further information.

Malabsorption of folic acid or $B_{12}$, as in sprue and related syndromes, needs to be studied with cobalt-60 $B_{12}$ and oleic acid $I^{131}$ absorption tests.

The mechanism of the megaloblastic anemia caused by anti-epileptic drugs seems to be a blockage of utilization of $B_{12}$ or folic acid, similar to that induced by aminopterin and other folic acid antagonists. The block is easily overcome by administering an excess of $B_{12}$ or folic acid without stopping the anti-epileptic drug.

The Mysoline induced megaloblastic anemia in

TABLE 1

| Date | RBC | HCT | HBG | Retic. | WBC | Platlets | N | L | M | E | Special Tests | Treatment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6/10/59 | | | 4 | | | | | | | | Bone marrow examination: megaloblastic anemia. | 500 cc. blood transfusion. |
| 6/11/59 | 1,700,000 | 19 | 5.5 | | | | | | | | Urine glutamic acid: heated, 0 mg./24 hrs.; unheated, 111.6 mg./24 hrs. GSH 150 MMLS/100 cc. RBC. Folic acid 0.55 mg. $10^6$/wk. $B_{12}$ 130 micrograms/100 ml. Serum ascorbic acid, 0.032 mg./100 ml. Serum dehydro-ascorbic acid, 0.625 mg./100 ml. | Mysoline discontinued. |
| 6/16/59 | 2,060,000 | 20 | 6.2 | | 2500 | 56,000 | 45 | 48 | 1 | 6 | Serum iron 246. | |
| 6/23/59 | 1,880,000 | 18 | 5.6 | .1% | 4100 | 231,000 | 39 | 46 | 12 | 3 | Serum iron 255. | |
| 6/24/59 | 1,500,000 | 18 | 5.5 | | 5200 | | | | | | Bone marrow: Megaloblastic anemia. | Mysoline 0.25 Gm. q. i. d. restarted. |
| 6/25/59 | | | | | | | | | | | | Folic acid ¼ mg. daily. |
| 6/28/59 | | 19 | 5.7 | .2% | 5300 | | | | | | Serum $B_{12}$ 130 mcg./100 ml. | |
| 6/30/59 | 1,620,000 | 17 | 4.6 | .3% | 6400 | 181,000 | 70 | 24 | 5 | 1 | | |
| 7/2/59 | | | | | | | | | | | | Transfusion 500 cc. blood. |
| 7/3/59 | | | 6 | | | | | | | | | Mysoline discontinued. |
| 7/7/59 | 1,800,000 | 18 | 6.2 | | | | | | | | | Penicillin and streptomycin discontinued. |
| 7/11/59 | | 19 | 5.9 | .7% | | | | | | | Free HCl. in gastric juice. | Penicillin and Gantrisin started. |
| 7/15/59 | | 18 | 5.8 | .8% | | | | | | | | Mysoline 0.25 Gm. q. i. d. Folic acid 5 mg. b. i. d. |
| 7/23/59 | 2,220,000 | 22 | 6.2 | 20.4% | 9000 | | 76 | 21 | 2 | 1 | Serum iron 63. | |
| 7/30/59 | 2,700,000 | 29 | 7.2 | 4.8% | 8400 | | 78 | 18 | 4 | | | |
| 8/3/59 | 3,150,000 | 30 | 8 | 2.4% | | | | | | | Serum iron 32. | Terramycin started. |
| 8/10/59 | 3,150,000 | 30 | 9 | 2.0% | 5200 | | 56 | 30 | 9 | 5 | BUN 5 Alk. Phos. 35 Bilirubin 0.5. Total protein 4.21 Al. 2.16 A/G 1.07 Glob. 2.05 Fasting ascorbic acid= 0 GSH = 150. | Terramycin discontinued. Kynex started. |
| 8/19/59 | | | 8.4 | | | | | | | | Schilling test 19% (normal range). | |
| 8/25/59 | | 37 | 10 | | 6100 | | 54 | 40 | 6 | | Serum iron 42. | |
| 9/4/59 | 4,090,000 | 37 | 10.8 | 0.2% | | 336,000 | | | | | Occult blood negative in stool. | |
| 9/8/59 | | 34 | 9.4 | | 8600 | | | | | | Free HCl. present on gastric analysis. | Imferon I. M. 250 mg. |
| 9/15/59 | 3,920,000 | 40 | 10.3 | .4% | | | | | | | | |
| 9/20/59 | 3,920,000 | 40 | 10.3 | .6% | 6400 | | | | | | | |
| 10/6/59 | 4,670,000 | | 11.2 | | | | | | | | Total protein 4.97<br>Albumin 2.04<br>Globulin 2.93<br>A/G ratio 0.69<br>Phosphorus 2.3<br>Alk. Phosphatase 14.0 | |
| 11/2/59 | 5,190,000 | 43 | 12.9 | | | | | | | | | |

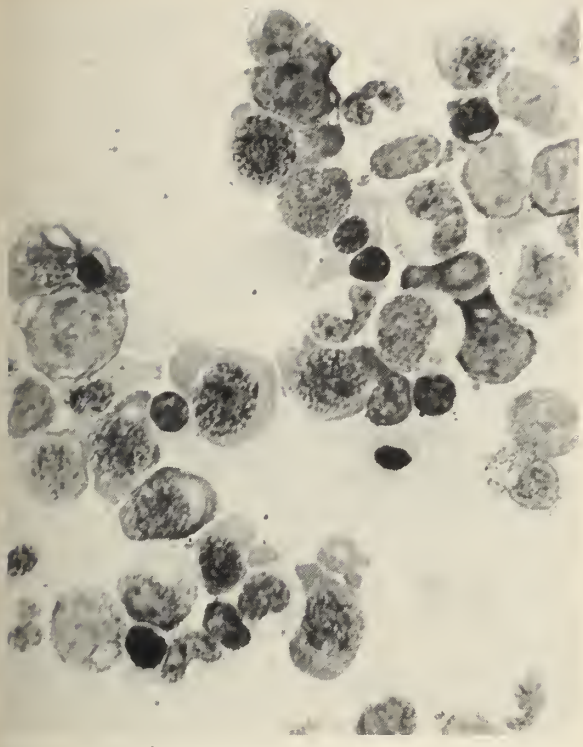


FIG. 1. *Sternal marrow showing megaloblastic and hyperplastic bone marrow.*

the present case did not respond to 14 days of adequate and supervised diet on the Longview State Hospital special medical ward, despite cessation of Mysoline therapy during this period. This tended to rule out dietary deficiency. During the following three weeks, she was given 0.25 milligram of folic acid daily for nine days in conjunction with Mysoline and then without Mysoline for 12 additional days. There was no response to this minimally optimal therapeutic dose of folic acid, partly perhaps by antagonism from the Mysoline and partly from the low grade fever and general toxicity. Then, on the regime of 10 mg. of folic acid daily, there was maximal hematologic and chemical response. Our therapeutic program probably eliminated dietary or drug induced deficiency of $B_{12}$ and folic acid, but it did not prove or disprove a block of folic acid or $B_{12}$ utilization.

It was postulated that a patient with a metabolic block in utilization of folic acid induced by an anticonvulsant drug would not respond to suboptimal doses of folic acid. This patient did not respond to 0.25 mg. of folic acid daily but did respond fully to larger doses. However, the patient was febrile and toxic during the period of study, and this may also be a factor in the failure of response to low dosage. Also, it might be that a 0.25 mg. daily dose of folic acid would be an adequate hematologic stimulant in most people, but, in this particular patient with her general toxicity, perhaps 1.0 mg. daily could have demonstrated the block. Pernicious anemia was ruled out by the normal gastric acidity, normal cobalt-60 $B_{12}$ absorption, and the low normal serum $B_{12}$ level. Malabsorption syndrome was not ruled out further than by the usual cobalt-60 $B_{12}$ absorption test.

Nutritional or dietary deficiency of folic acid was perhaps not ruled out as completely as one would like. The period of 14 days of adequate diet with no primidone or folic acid was complicated by mild fever and toxicity. So, perhaps, the nutritionally adequate diet was not really adequate for heightened metabolic requirements of a sick person.

## Summary

A case of megaloblastic anemia secondary to primidone therapy is discussed. The mechanism of production of the anemia is probably due to a block of utilization of folic acid or $B_{12}$ by the primidone, analogous to the block induced by folic acid antagonists such as aminopterin. Nutritional deficiency of Vitamin $B_{12}$ or folic acid could conceivably cause megaloblastic anemia in institutionalized epileptics. Such a nutritional deficiency was not entirely disproved in this case.

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# On a New Source of X-Rays

WILLIAM G. MYERS, Ph. D., M. D.

THE RADIOGRAPH in figure 1 was made by means of X-ray and $\gamma$-ray photons emitted when radioactive Iodine-125 decays. Calculations based on data in the literature indicate that about 95 per cent of the 144 photons emitted in each 100 disintegrations, in the narrow low-energy range of 27.2–35.4 kev, are the characteristic K X-rays of tellurium which follow electron capture and internal conversion processes,[1] as shown in Table 1. Potential energy stored temporarily in the radioiodine-125 nucleus thus becomes manifest predominantly in the form of X-rays during decay that occurs with a half-time of 57.4 days.[2] Because I-125 is a source of *characteristic* X-rays almost entirely, and the energy for the creation of them is nuclear in origin instead of extranuclear (as in a röntgen-ray tube), I-125 may be thought of as "a new source of X-rays" distinctly different from that described by Professor Röntgen in 1895[3] in the announcement of his monumental discovery, "On a New Kind of Rays."

TABLE 1. *Radioiodine-125 Photons for Radiography*

| Type | Energy in kev | Number Emitted Per 100 Distintegrations | % of Total |
|---|---|---|---|
| $K\alpha_1$ X-ray | 27.5 | 74.4 | 51.6 |
| $K\alpha_2$ X-ray | 27.2 | 38.2 | 26.5 |
| $K\beta_1$ X-ray | 31.0 | 20.2 | 14.0 |
| $K\beta_2$ X-ray | 31.7 | 4.0 | 2.8 |
| Gamma-ray | 35.4 | $7\pm2$ | 5 |
| Total 27.2–35.4 kev Photons in each 100 Distintegrations | | $144\pm6$ | |

## Point Source of I-125 X-Rays

The I-125 X-ray "point source" used to produce the radiograph was made by transferring highly concentrated I-125, as iodide, that was contained in only about 0.1 ml. of Normal NaOH, into the tip of a plastic needle guard tube, by means of a very long capillary pipet. The internal diameter near the tip was 1-2 millimeters so that the Iodine-125 solution, which extended only a few millimeters up the long axis of the tube, was held in place by capillarity. The open end was plugged with a small cork to prevent loss by evaporation. This little I-125 X-ray "machine" weighed about a gram, and there were no high tension wires or other electrical apparatus as in conventional röntgenography.

The tube was inserted into a hole bored in a large cork held in a clamp attached to a stand to permit adjustment of source-to-subject distance readily. Minimization of scatter was assured by projecting the tip of the plastic tube about an inch beneath the cork holder and its supporting clamp. The source was quickly transferred with long tongs from the cork into a lead shield between exposures. Protection was easy because the calculated "narrow beam" half-thickness of 27.4-kev photons (80 per cent of those emitted by I-125) in lead is only 0.0015 centimeter.[1] It will be noted how "opaque" the 0.01-inch thick lead foil, used for lettering the radiograph, was to the I-125 protons. This is pictorial proof that protection and containment are readily simplified with I-125, as pointed out previously.[1]

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Submitted May 9, 1962.

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## Exposure, and Intensity-Time Unit

The cadaver hand used in the radiograph was placed on a cardboard cassette loaded with Ansco Non-Screen X-ray Film. The exposure required about 5 "Curie-minutes" when the source was 50 centimeters above the hand. This unit of exposure was contrived to demonstrate the practicability of fabricating I-125 X-ray machines when this radionuclide becomes available in large quantities. It indicates the reciprocal relationship between the strength of source and time required to make a satisfactory radiograph. By calculation, I conclude the same radiograph could have been made at the same geometry in 1 minute had there been 5 Curies (5,000 millicuries) of I-125 in the source, or in only 3 seconds were 100 Curies present in it.

There were about 7 millicuries of I-125 in the shipment made from Oak Ridge National Laboratory, April 24, 1961. Due to loss in transfer, and decay, it is estimated that about 4 millicuries were present when the radiograph was made in mid-May 1961. Actually, 1200 minutes (20 hours) were required for the exposure with such a weak source. Hence the calcu-

lated value was 4 millicuries X 1200 minutes/1,000 = 5 Curie-minutes. When the distance from the I-125 X-ray source to the hand was halved, the exposure time was decreased to one-fourth, in accordance with the inverse square law. The resultant radiograph showed enlargement of structures and distortion of relationships among them. However, these would often be acceptable in military applications

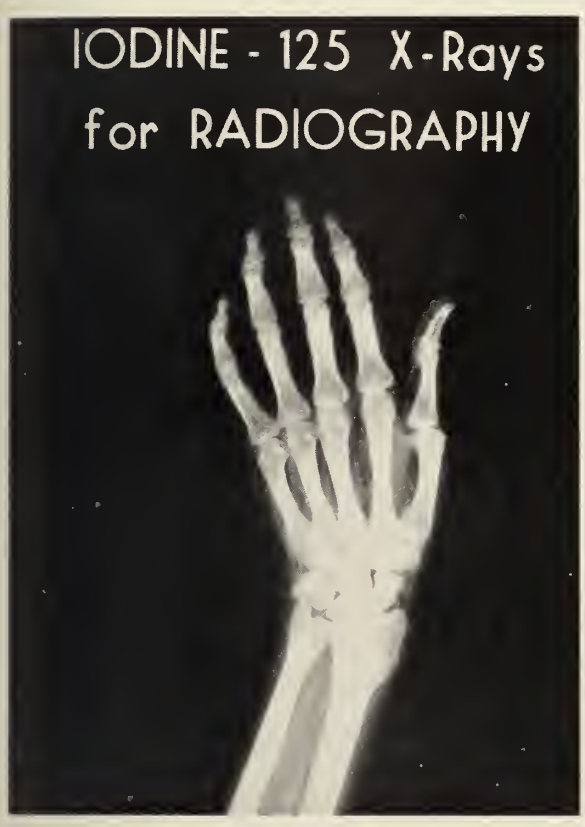



FIGURE 1

of a readily portable I-125 X-ray machine in the field; and they would sometimes be advantageous in the operating room or in industrial and geophysical applications.

### Radiographic Excellence

The excellent quality of the original radiograph was due not only to photoelectric absorption of the 27.2 - 35.4 kev photons in bone, but also the soft structures were revealed in detail because a large part of these photons are absorbed by the all-or-none photoelectric process in water as well, so that scattering by Compton interactions is greatly diminished.[1] Also, the sensitivity of films is near maximum for photons having these energies.[4] This may be due in part to resonance absorption[5] because the energies are only slightly above the 25.5-kev K edge of the silver in emulsions.[6]

### Practicable Portable I-125 X-Ray Machine Being Designed

The original of the radiograph in the figure was displayed at meetings of The Ohio State Radiological Society in Columbus, May 20, 1961, and The Society of Nuclear Medicine in Pittsburgh, June 14-17, 1961. Calculations indicate the high specific activity of I-125[1] will permit preparation of "point" sources of it containing several Curies, or perhaps even up to a few hundred Curies, and at reasonable costs. Such a source, as palladous iodide, $PdI_2^{125}$, presently is being prepared at the Isotopes Development Center of Oak Ridge National Laboratory. It should be sufficiently strong to enable me to study the feasibility of constructing a practical portable I-125 X-ray machine that may not weigh more than a few pounds. Radiographs similar to that in the figure may then be made with it in less than a minute.

Acknowledgments: Eleanor Poehlmann ably assisted in making the radiographs. Robert Bullock, chief technician in the Department of Radiology, suggested that non-screen film would be most suitable for the purpose. Dr. Philip Baker at Oak Ridge National Laboratory had the highly concentrated I-125 solution prepared, on special request. J. C. Vanderleeden made some of the calculations in the table.

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HYPOMETABOLIC TREATMENT OF HEART DISEASE. — From their own experience and a review of the literature, the authors concluded that the use of radioactive iodine to induce the hypometabolic state in the euthyroid patient is often effective in controlling (1) severe angina pectoris due to coronary arteriosclerosis or rheumatic heart disease, (2) congestive heart failure, (3) recurrent tachycardia, and (4) uncontrolled chronic auricular fibrillation. Other antithyroid drugs are also effective in treating these conditions, but their effective dosages are so large that they often produce adverse toxic effects. These findings are illustrated by several case reports. — (ABSTRACT): Eliot Corday, M. D.; Henry L. Jaffe, M. D., and David W. Irving, M. D., Los Angeles: *American Journal of Cardiology*, 6:952-960, (November) 1960.

# Fascial Plane Gas Gangrene Complicating Leukemia

## Case Report

FRANKLIN G. HOFFMAN, M.D.; BERKELEY SLUTZKER, M.D.; DAVID SHEIDLER, M.D., and PAUL M. COE, B.S.

PHYSICIANS are well aware that bacterial infections not infrequently complicate the course of patients with leukemia. The introduction of antimetabolic drugs and steroids into the treatment of the leukemias has been postulated[1] as possibly altering susceptibility of the patient to certain organisms. The following case report illustrates an unusual instance of anaerobic cellulitis due to *Clostridium feseri* in a patient with myelogenous leukemia.

### Report of Case

A 64 year old white man was admitted to the Veterans Administration Hospital, Dayton, Ohio, for the first time on August 4, 1960, with the chief complaint of localized right chest pain of about one week's duration.

The patient had been treated for rheumatoid arthritis by his local physician over a period of 17 years, receiving acetylsalicylic acid for prolonged periods of time. During the six months prior to admission, he had been receiving steroids daily. The pain in the right anterolateral chest wall was nondescript, and there was localized discoloration. The pain was unrelated to respiration or position, and there was no history of unusual local trauma. There was no history of fever, chills, cough, or hemoptysis. No blood counts or other laboratory studies had been done for several years.

The past history was otherwise unremarkable. The patient retired from farming in 1949 because of disabling rheumatoid arthritis. His disease had progressed for the two years prior to admission, requiring crutch ambulation because of his marked joint deformities. For one week prior to admission he had been unable to use the crutches because of local tenderness in the discolored area in the lower right anterior axillary region and had therefore been bedridden. There was no history of break in the skin integrity.

**Physical Examination** revealed a fairly well-developed, poorly nourished, white man who showed evidence of recent weight loss. He did not appear to be acutely ill. Admission temperature was 100.6°F (38.1°C) orally. There was conjunctival pallor and slight soft tissue swelling in the right anterolateral chest wall below the axilla, with ecchymoses of the right side of the back extending from the shoulders to the lumbar area. The heart was not enlarged and except for grade 1 localized blowing apical systolic murmur there were no cardiovascular abnormalities found. The firm edge of the spleen could be felt just below the level of the umbilicus. The liver was not enlarged. The examination of the respiratory tract was unremarkable. There was dependent edema of the feet and marked deformities of the fingers with ulnar deviation of the wrists, elbows and knees, felt to be consistent with the diagnosis of chronic rheumatoid arthritis. There were no other significant findings.

**Laboratory Data.** The admission white blood cell count on August 4, 1960, was 195,000 per cubic millimeter with immature forms in the peripheral blood; hemoglobin was 5.8 Gm. per 100 cc. (figure 1). Bone marrow and peripheral blood smears examined by both Wright-Geimsa and supravital stains were consistent with the diagnosis of myelogenous leukemia. Platelets appeared grossly adequate. The urine contained 8-10 white cells per high power field and occasional granular casts and a trace of albumin, all of which cleared during hospitalization after the institution of therapy (for which see figure 1). Blood urea nitrogen was 18 mg. per 100 ml.; Coombs' tests, direct and indirect, were negative. Total serum bilirubin 1.0 with a direct of 0.4, and indirect of 0.6. VDRL was nonreactive. Stools for occult blood were negative. Blood culture taken before antibiotics were administered showed no growth.

X-rays of the chest (figure 2) showed haziness in the right chest wall and swelling of the right lateral chest wall, and serial films showed soft tissue swelling with the formation of interstitial gas bubbles and later massive fluid levels suggestive of abscess with air fluid levels. X-rays taken after surgery and one month later showed normal soft tissues and intrathoracic contents.

**Hospital Course.** At the time of admission the patient's oral temperature was 100.6°F (38.1°C). This dropped to normal on the second hospital day and rose no higher than 99°F (37.2°C) until the time of surgery. Busulfan was instituted on August 5, 1960, and continued until September 1, 1960, being re-started on October 18. Sulfamethoxypyridazine was given from August 19 to August 28, because of pyuria. The patient then received tetracycline from August 25 to September 1, 2.0 Gm. per day, for the same reason.

There was right anterolateral chest discomfort and tenderness requiring analgesics and narcotics for relief. The swelling in the region of the right anterolateral chest increased, becoming very notable approximately 10 days after admission. On August 17, thirteen days after admission, crepitation was found in the lower portion of this mass, and aspiration produced 240 cc. of dark bloody fluid. Smears of this material showed a gram-positive bacillus. Re-


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Submitted August 1, 1961.

peat aspiration on August 20 produced a smaller amount of similar material. Pure cultures of *Clostridium feseri* were grown from both specimens. On August 24 similar material was obtained from the right infrascapular area. This area was again aspirated for the relief of pressure on August 30, at which time the space was irrigated with crystalline penicillin solution. With the establishment of the diagnosis, penicillin and streptomycin were started and a total of 100,000 units of gas gangrene antitoxin (40,000 units initially followed by 60,000 units the following day) was given intramuscularly.

Wide incision and drainage of the abscess was performed on August 31, 1960, with removal of approximately 3000 cc. of very dark, bloody, necrotic material. The skin was intact prior to the time of surgery. The abscess cavity was located deep to the muscular insertion of the right latissimus dorsi, extending down to the chest wall, but no involvement of skeletal muscles or structures of the thoracic cage was present. There was extensive necrosis of the fascia. Cultures and smears obtained at the time of surgery and from the postoperative drainage, which continued for two and one-half days after surgery, were bacteriologically sterile. Secondary closure of the incision was accomplished on October 4, 1960.

At no time during hospitalization did the patient appear acutely ill, but prior to surgery multiple transfusions were necessary to maintain the hemoglobin at levels above 8 Gm. per 100 ml. (figure 1). Following the institution of antibiotics and surgical drainage of the area, the patient said he felt much better, his appetite returned, and he gained 25 pounds in the next four weeks. The spleen decreased in size with busulfan therapy, began to enlarge again after cessation of the drug, and shrank again upon antimetabolite resumption (see figure 1).

The patient's crutches were obtained from his family and the armrests soaked in sterile saline for culture purposes. Anaerobic culture of the solution thus obtained grew *Clostridium feseri*. The patient had not used these crutches between the onset of his discomfort (see history above) and the time the culture was obtained.

Attempts were made to isolate *Clostridia* in the patient's stool, but only after extensive antibiotic therapy had been administered, and although a gram-positive rod was seen it could not be isolated.

## Discussion

Pulaski[2] and Altemeier et al.[3] suggest classification of clostridial infections on the basis of clinical characteristics. The most serious and rapidly fatal type involves progressive destruction of skeletal muscle with gas formation as a late sequela, and is the form of which most physicians are aware. The less fulminating variety is localized to the fascial planes and subcutaneous tissues with gas formation noted early. It is felt that the case reported here represents an instance of the latter type of gas bacillus infection.

The finding of the causative organism on the patient's crutches, in the absence of demonstrable break in the skin, poses the question of the origin of the infection.

One may postulate either of two sources: either (1) the organism arrived at the site of fascial plane

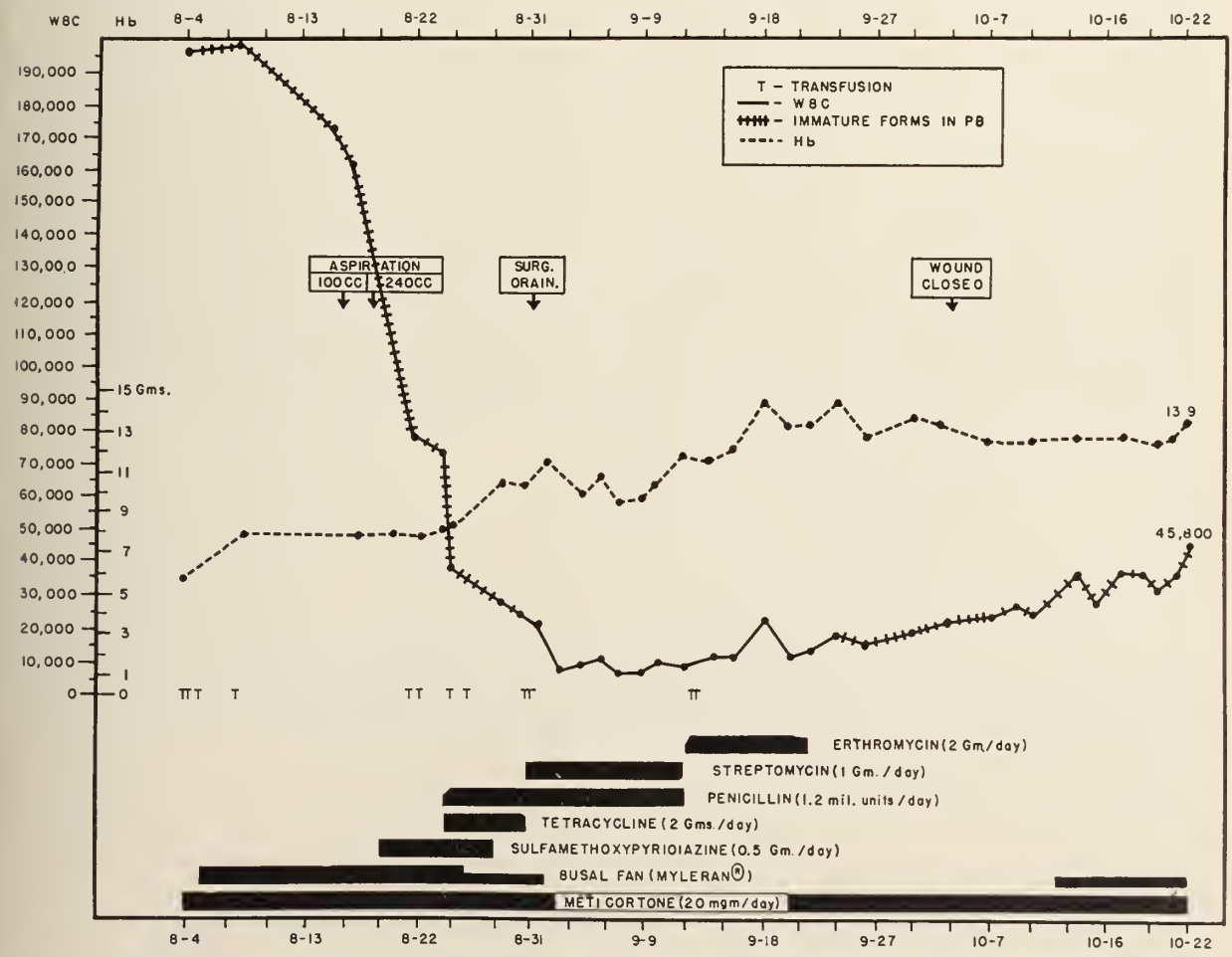



FIG. 1. *Graphic record of the patient's hospital course. Note the reappearance of immature white cells in peripheral blood, confirming the diagnosis of myelogenous leukemia as opposed to that of leukemoid reaction in response to infection.*

infection via the bloodstream (presumptively from the colon), or (2) the *Clostridia* gained entry through the skin from the contaminated crutches.

If we examine the latter alternative we must account for an apparently reliable history of unbroken skin and the finding of intact integument at the time of admission to the hospital. This forces us to postulate migration of a pathogenic *Clostridia* through what would ordinarily be an impervious barrier. Here it would be tempting to invoke lowered local inflammatory (protective walling-off) response related to prolonged steroid therapy as a theoretical, but unconfirmable possibility.

In other cases of clostridial infections complicating leukemia,[5] the reporting physicians were able either to demonstrate or to postulate leukemic infiltrates in the bowel as a site of entry into the bloodstream of *Clostridia* from the bowel lumen. Two of their cases were myelogenous leukemia, as was ours.

Cases of clostridial bacteremia and/or septicemia[5,7] in the absence of external wounds have been reported where overt lesions (i. e., cancer) of the colon have broken the integrity of the colon lining.

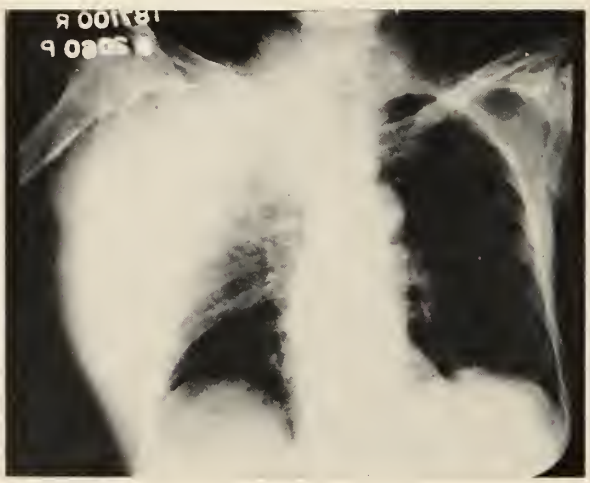


Fig. 2



Fig. 2-A

FIG. 2 AND FIG. 2-A. *X-rays taken on 16th hospital day, showing massive swelling over right chest wall with enlarged section on right (2-A) demonstrating radiologic evidence of air in soft tissues.*

The probability of local trauma (crutches) with the development of a small hematoma, providing ideal anaerobic conditions for the growth of *Clostridia,* existed in this case, regardless of how the *Clostridia* arrived at the site. Valentine,[7] in a case of clostridial myositis complicating cancer of the cecum, discusses the mechanism of such transmission and the proclivity of these anaerobes for such sites of local injury.

Was the course of this disease altered by the patient's medication with steroids or antimetabolites? Here again it is very tempting to invoke causal relationship, especially in a patient with basic reticuloendothelial disease (leukemia), involving the polymorphonuclear cells and receiving additional insults in the form of a specific antimetabolite for this system (busulfan). Certainly the disease progressed fairly rapidly during a period of antileukemic therapy. The finding of clostridial infection in patients with leukemia by others,[1,5,6] as well as in patients receiving antimetabolites for other neoplastic diseases,[4] makes this an attractive hypothesis but probably represents only increasing facilities for, and attention to exact bacteriological diagnosis of the complications suffered by these patients.

Of interest was the relative absence of systemic toxicity despite evidence of rapidly progressive and extensive cellulitis and necrosis. Whether the steroids were of import here remains conjectural. The patient's response to antibiotics, surgical incision and drainage and antitoxin was most gratifying, but it should be noted that the area of infection had become bacteriologically sterile before radical drainage was instituted (i. e., after tetracycline and penicillin therapy).

## Summary


1. A case of fascial plane *Clostridium feseri* infection in a patient with myelogenous leukemia is reported.

2. The possible sources and routes of the infection are discussed.

3. Theoretical relationship of antimetabolites and steroids to the course of the disease is noted.

4. There was excellent clinical response to anti-

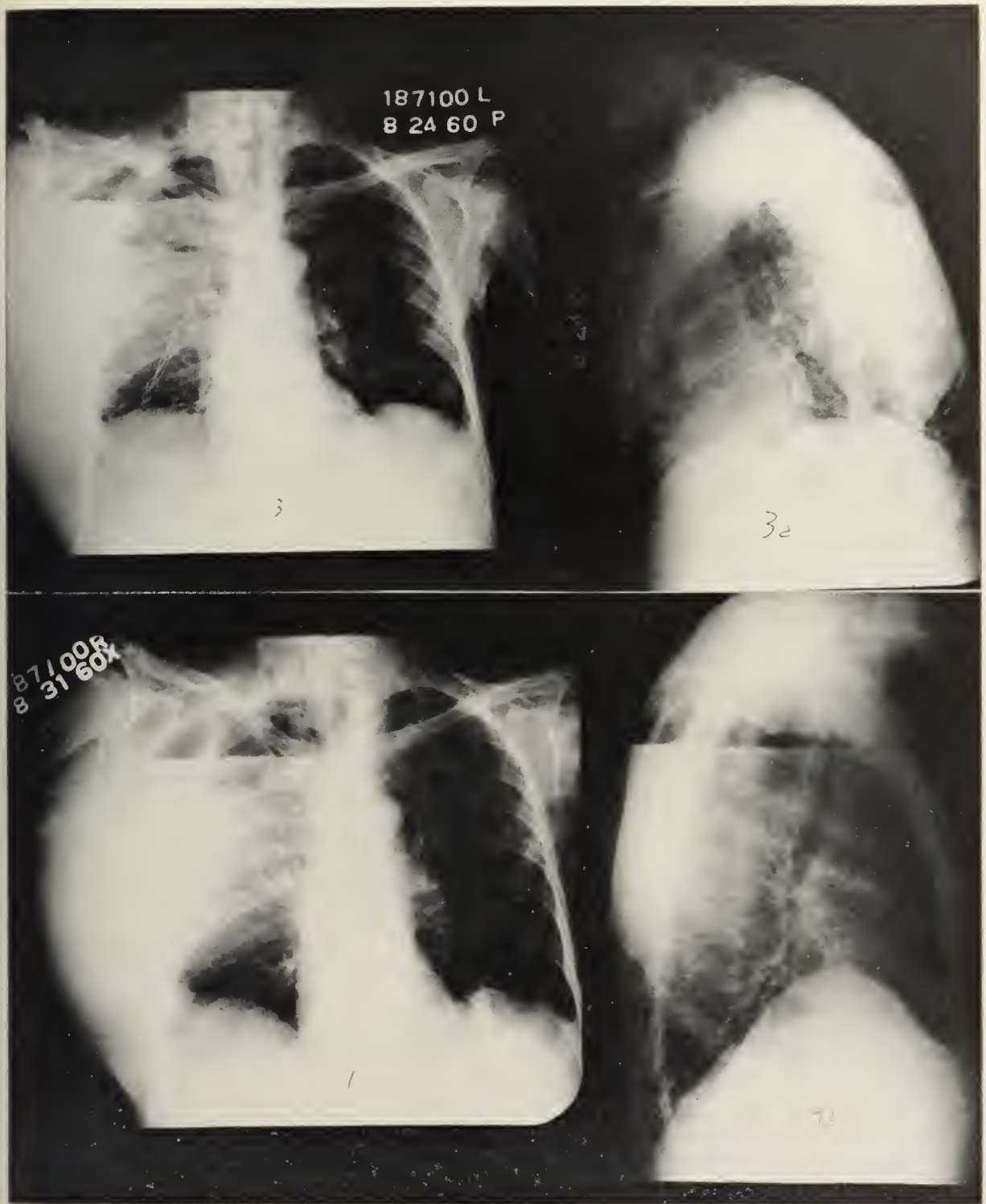



FIG. 3. *X-rays taken on 20th (upper) and 27th (lower) hospital days showing progression from multiple loculated abscesses (8-24-60) to communication from front to back around the side of the chest (8-31-60).*

biotics followed by surgical drainage with control of the leukemia by antimetabolites.

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# Polycythemia, Brain Tumor, and Arterial Oxygen Unsaturation

## A Case Report

JAMES F. LEARY, M. D.

CENTRAL nervous system signs in polycythemia rubra vera have been considered a common manifestation of the disease.[1-5] There now seems to be a loosely defined group of primary lesions involving the central nervous system that may be accompanied by erythrocytosis. This association may be noted in central nervous system neoplasms, usually vascular in origin and infratentorial in location.[6-8] Fortunately, it is apparently unusual that central nervous system neoplasms have been noted in association with the established erythrocytosis, leukocytosis, thrombocytosis, and splenomegaly of polycythemia rubra vera.

Attention continues to be called by various observers to the infrequency of significant arterial oxygen unsaturation in the course of polycythemia rubra vera.[4, 9]

A case is reported, presenting the clinical findings of polycythemia rubra vera, progressing to show marked central nervous system involvement, and ultimately proven to have a primary glioblastoma multiforme of the left temporal lobe. Studies were accomplished in this case indicating significant unsaturation.

### Case Report

*History of Present Illness.* A 59 year old white, male tool and diemaker was admitted to Brown General Hospital, Dayton, Ohio, for the first time on September 15, 1958 with complaints of paresis of the right face of three days duration. Some hesitancy of speech had been apparent and there was ill-defined weakness of both lower extremities without an associated sensory deficit. Plethoric facies had been apparent over an undetermined period of time. This was initially felt to be associated with a protracted history of ethanolism.

*Past History.* The patient had been a diabetic since 1954 and had been receiving 10 units of lente insulin daily. There was no history of venereal disease. Appendectomy had been accomplished in the remote past. A review of systems failed to elicit complaints of dyspnea or any other symptoms of congestive heart failure.

*Physical Examination.* His height was 5′ 10½″; weight 143 lbs.; temperature 98.4; pulse rate 88 per minute and regular; respiratory rate 20 per minute; and blood pressure 218/110. The patient was a well-developed, well-nourished white man with plethoric facies, who was alert and oriented. The pupillary reflexes were intact. There was evidence of diabetic retinopathy. The lungs were essentially clear to percussion and auscultation. Examination of the heart was not remarkable. The liver edge was palpable two fingerbreadths inferior to the right costal margin and was smooth and nontender. The spleen was not palpable. Femoral pulses were intact. There was mild weakness of the right upper extremity. The deep tendon reflexes of the lower extremities were hypoactive. No pathologic reflexes were elicited, and there were no additional localizing neurologic signs.

*Laboratory Studies.* The initial hemogram on September 17, 1958 showed hemoglobin 19.8 Gm./100 ml. and hematocrit 63 per cent. The white blood cell count was 13,550 per cu. mm. and the differential showed 77 neutrophils, 16 lymphocytes, 1 monocyte, 1 basophil, and 5 eosinophils. The values for subsequent hemograms may be noted in Table 1. These demonstrated a continuing erythrocytosis, leukocytosis, and thrombocytosis. Blood volume studies were not obtained. A fasting blood sugar was 185 mg. per 100 ml. Subsequently, on September 23, 1958 a fasting blood sugar of 133 mg./100 ml. was obtained. Blood urea nitrogen was 15 mg./100 ml. and the serum sodium 129 mEq. per liter. On September 26, 1958 the $CO_2$ was 24 mEq./L. sodium 122 mEq./L., potassium 6.3 mEq./L., and chlorides 89 mEq./L. The reticulocyte count was 0.2 per cent, total serum bilirubin was 0.4 mg. per 100 ml. Random urinalyses revealed no abnormalities and a phenolsulfonphthalein excretion on October 14, 1958 revealed 20 per cent excretion in the first 15 minutes. The serologic test for syphilis was negative.

Electrocardiograms revealed an old anteroseptal and basilar myocardial infarction.

*X-rays.* A skuli series obtained on October 13, 1958 revealed no abnormalities. A chest x-ray obtained during this admission was within normal limits, except for minimal aortic arteriosclerosis (Fig. 1). The frontal cardiac area and other mediastinal structures were not remarkable for the patient's age, and the lung fields were clear and without active pulmonary disease. Some slight elevation of the left hemidiaphragm was felt not to be of clinical significance (Fig. 1).

Cardiopulmonary function studies were obtained. These values and subsequent pulmonary functions are shown in Tables 2, 3, and 4. The usual ventilatory studies were noted to be within relatively normal limits. However, a significant increase in the residual volume was apparent on all studies. Arterial blood studies on October 17, 1958 and December 11, 1958 may be seen in Tables 3 and 4.

Submitted August 21, 1961.

### *The Author*

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FIG. 1. *PA Chest film showing some elevation of the left hemidiaphragm, but no other significant abnormalities.*

Initially, striking arterial oxygen unsaturation was evident, with a value of 84.5 per cent at rest, and failure to fully saturate was noted after $0_2$ inhalation.

*Hospital Course.* This 59 year old white man was admitted to Brown General Hospital on September 16, 1958 with known diabetes mellitus and complaints of increasing weakness of the extremities. The patient was started on a 2400 calorie diabetic diet and 25 units NPH insulin with adequate control of his diabetes. With the history of relatively heavy ethanolism and known diabetes mellitus, some consideration was given to the possibility of a peripheral neuropathy. Hypertension was evidenced early in this hospital course; the subsequent systolic pressures ranged between 150-170 mm/Hg. with diastolic values ranging from 90-100 mm/Hg. Interest centered on the evaluation of the persistent erythrocytosis, leukocytosis, and thrombocytosis, and the patient was seen and followed both by the Hematology and Cardiology services.

The sternal marrow revealed intense pan-marrow hyperplasia. Although definite arterial oxygen unsaturation was demonstrated, it was felt that polycythemia rubra vera was present and, accordingly, on October 17, 1958, 2 microcuries of P-32 was administered orally. Complaints of paresis of the lower extremities had largely disappeared by the third hospital day, and a lumbar puncture was not done.

The patient was subsequently discharged on October 30, 1958 with appropriate follow-up to be made.

## Second Hospital Admission

The patient was re-admitted on November 28, 1958 complaining of slow mentation, and there was a suggestion of a right hemiparesis. A staggering gait had been apparent intermittently. A blood pressure of 174/100 was obtained. There was mild paresis of the right upper extremity and vibratory sense appeared to be impaired over the lower extremities, but the deep tendon reflexes persisted within physiological limits and the cranial nerves were felt to be intact.

Laboratory studies revealed hemoglobin 16.3 Gm./100 ml. with hematocrit of 58.5 per cent. The numerical platelet count was 2.88 million and the white blood cell count was 14,750 with the differential showing a shift to the left. A normal intravenous pyelogram was obtained; chest films were unchanged, and the electrocardiogram was stable.

The patient's complaints were felt related to neurologic involvement by the primary disease of polycythemia rubra vera with, perhaps, multiple small thrombotic events superimposed on cerebral arteriosclerosis. The patient was subsequently discharged on December 23, 1958 without additional therapy.

## Third Hospital Admission

He was admitted for the final time on January 27, 1959 with evidence of progressive mental confusion and deterioration, and he was disoriented in all spheres. The hemoglobin was 16 Gm./100 ml. and hematocrit 56 per cent. The numerical platelet count was 3.66 million and the white blood cell count 20,500.

The pupils reacted very sluggishly to light and in accommodation, and anisocoria was noted with the left pupil larger than the right. Diabetic retinopathy, with hemorrhages, exudates, and associated micro-aneurysms, persisted bilaterally. Definite right facial paresis was noted, and the deep tendon reflexes on the right were accentuated but no pathological reflexes were elicited. A lumbar puncture was done on January 28, 1959 and the opening pressure was 220 mm. and the closing 140 mm. The cell count was 39 RBC of which 90 per cent were crenated. The spinal fluid protein was 60 mg./100 ml. A cerebrospinal fluid sugar of 142 mg. per 100 ml. was obtained but simultaneous blood sugar was not determined.

A skull series obtained on January 29, 1959 showed no abnormalities. An electroencephalogram was interpreted as abnormal with a slow wave focus in the left frontotemporal area, consistent with a focal lesion.

Anticoagulation was considered but was deferred because of the possibility of intracranial bleeding. On January 28, 1959 a phlebotomy was attempted, but only 250 cc. of blood was obtained. With progression of mental confusion, nausea and frequent emesis were noted, and parenteral fluids were required. On January 31, 1959 approximately 750 cc. of whole blood was obtained by phlebotomy.

## Cincinnati Hospital Admission

The patient was then transferred to the Veterans Administration Hospital, Cincinnati, Ohio for additional diagnostic studies and therapy. Following admission to that VA facility on February 6, 1959 the patient was observed for a period of 12 hours on the Neurosurgical service and the right hemiplegia was noted to become more profound. A Babinski sign was present on the right and the left pupil was 6 mm. in diameter while the right was 2½ mm. There was no suggestion of papilledema. A skull series revealed the pineal to be displaced toward the right and, accordingly, a left carotid angiogram was done (Fig. 2). The study was compatible with a mass in the region of the left temporal lobe, and on February 7, 1959 a left temporal craniotomy was done with a subtotal removal of a large



FIG. 2. *Left carotid angiogram showing elevation of the middle cerebral group, and indicating a large mass lesion of the left temporal lobe.*

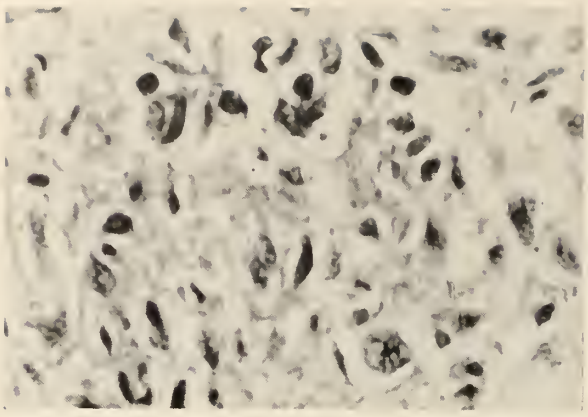


FIG. 3. *Photomicrograph CNS neoplasm (approximately 440X) showing proliferating, bizarre, spindle-shaped, astrocytes, sometimes multinucleated, and interpreted as a glioblastoma multiforme.*

left temporal tumor mass which microscopically proved to be a glioblastoma multiforme (Fig. 3).

On February 9, 1959 the hemogram revealed hemoglobin of 14.2 Gm./100 ml. with hematocrit of 49 per cent. The numerical platelet count was 918,480 and white blood cell count 32,600.

Postoperatively, focal seizures appeared in the right hand and face, and there was electrocardiographic evidence of extension of the previously described myocardial infarction. Anticoagulants were initiated but the patient became comatose and died on February 18, 1959.

*Autopsy findings.* Six hundred milliliters of straw-colored fluid was noted in the left pleural space. There was thick, yellow, shaggy exudate covering the posterior and lateral surfaces of both lower lobes. The right lung weighed 1050 grams, and the left 875 grams. There were palpable nodules noted over both upper lobes, 2-3 cm. in diameter, representing abscess cavities and containing purulent material. Several thrombi were identified in the distal pulmonary arteries, without obvious pulmonary infarction.

Examination of the heart revealed a fine fibrinous deposit over the apex, pale yellow in appearance. Sections revealed a mottled-appearing area of hemorrhage. The coronary ostia were patent and, although the coronary arteries showed moderate atherosclerosis, no thrombi were noted. Microscopic examination confirmed the diagnosis of recent myocardial infarction.

Just distal to the pyloric sphincter were two shallow ulcers measuring 2 by 1 centimeters and 3 by 3½ centimeters. There was no associated hemorrhage. The liver weighed 2230 Gm. The spleen weighed 650 Gm. and had a grayish blue surface; it contained a 4 cm. soft flocculent area, and on section, multiple areas of brown necrotic tissue with hyperemic borders were noted, which microscopically proved to be areas of splenic infarction. The right kidney weighed 190 Gm., the left kidney 100 Gm. Microscopically there was evidence of focal acute pyelonephritis, and nephrosclerosis.

Examination of the brain revealed a necrotic, yellow-red mass in the area of the left temporal lobe, containing a 4

TABLE 1. *Hematology*

| Date | Hemoglobin | Hematocrit | WBC | RBC (Million) | Platelets (Million) |
|---|---|---|---|---|---|
| September 17, 1958 | 19.8 | 63.0 | 13,550 | .... | |
| September 23, 1958 | 17.6 | 59.0 | 13,650 | .... | |
| September 25, 1958 | 17.7 | 61.5 | 15,540 | 5.7 | |
| September 26, 1958 | .... | .... | 17,300 | 6.7 | 2.7 |
| September 30, 1958 | 19.2 | 64.5 | 19,900 | 6.4 | 2.9 |
| October 17, 1958 | 17.4 | 63.0 | .... | 6.5 | |
| (2 millicuries P-32 orally on October 17, 1958) (Phlebotomy of 500 milliliters on October 27 & 28, 1958) | | | | | |
| October 29, 1958 | 15.6 | 55.5 | 20,150 | .... | .... |
| November 28, 1958 | 16.3 | 58.5 | 14,750 | 6.7 | 2.8 |
| December 2, 1958 | 16.0 | 57.0 | 12,100 | | |
| December 10, 1958 | 16.8 | 58.0 | 14,000 | 5.9 | 2.6 |
| January 27, 1959 | 16.0 | 58.0 | 20,100 | 6.4 | 3.6 |
| January 28, 1959 | 16.0 | 55.0 | 16,200 | | .... |
| (Phlebotomy of 250 cc. on January 28, 1959) | | | | | |
| January 29, 1959 | 16.6 | 57.0 | 30,200 | 6.3 | 3.8 |
| (Phlebotomy of 750 cc. on January 31, 1959) | | | | | |
| February 2, 1959 | 13.4 | 46.0 | 12,000 | 5.1 | .... |
| February 9, 1959 | 14.2 | 49.0 | 32,600 | 5.3 | 0.92 |

TABLE 2. *Ventilatory Functions*

| | PREDICTED | OBSERVED | PER CENT |
|---|---|---|---|
| October 24, 1958 | | | |
| Vital Capacity (cc) | 3760 | 4085 | 108.6 |
| Timed Vital Capacity (3 Sec.) | 95% | 3760 | 92.1 |
| Maximum Breathing Capacity (Liters/minute) | 122 | 92.4 | 75.7 |
| Functional Residual Capacity* | | 5113 | .... |
| Total Lung Capacity (Seated) | | 7740 | .... |
| Residual Volume (Seated) | | 3655 | .... |
| Residual Volume/Total Lung Capacity (%) | 30.8 | 47.2 | |
| *Helium Closed-Circuit Technique | | | |
| December 9, 1958 | | | |
| Vital Capacity (cc) | 3760 | 4395 | 116.9 |
| Timed Vital Capacity (3 Sec.) | 95% | 4230 | 96.2 |
| Maximum Breathing Capacity (Liters/minute) | 122 | 120.3 | 98.6 |
| Functional Residual Capacity* | | 4787 | .... |
| Total Lung Capacity (Seated) | | 7332 | .... |
| Residual Volume (Seated) | | 2937 | .... |
| Residual Volume/Total Lung Capacity (%) | 30.8 | 40.0 | .... |
| *Helium Closed-Circuit Technique | | | |

cm. blood clot. The area of destruction was noted to continue back to the anterolateral margin of the occipital lobe. The brain weighed 1450 Gm. and there was marked broadening and fattening of the gyri. The middle cerebral vessels contained a moderate number of atheromatous plaques. Microscopic examination of the temporal lobes revealed a necrotic neoplasm with marked proliferation of bizarre, sometimes multinucleated astrocytes with associated necrosis and edema (Fig. 3).

## Discussion

This 59 year old white man's early course suggested polycythemia rubra vera. There was evidence of panmarrow hyperplasia reflected in the peripheral blood by erythrocytosis, leukocytosis and thrombocytosis. As is well recognized, the early onset and, in fact, progression of central nervous signs and symptoms are so common in the course of polycythemia rubra vera that they might even be considered a part of this clinical entity.[1-5] The absence of a palpable spleen did not deter one from making this specific diagnosis.

Comroe[10] has delineated the general causes of arterial oxygen unsaturation. Hypoventilation from any cause should be accompanied by evidence of $CO_2$ retention, and arterial unsaturation should readily improve with oxygen inhalation. In this patient we were unable to obtain complete oxygen saturation and the $CO_2$ content was within normal limits for this laboratory. (See Tables 3 and 4.) Diffusion defects are characterized by aggravation of the existing state of saturation following exercise while this patient increased his oxygen saturation from 89.1 per cent to 93.5 per cent (Table 4). Similarly, arteriovenous shunts are generally aggravated by exercise. Classically, however, patients with functional arteriovenous shunts fail to saturate completely following oxygen inhalation. On repeat examinations, this patient reached a maximum oxygen saturation of 96.5 per cent (Table 4). The so-called physiologic shunt, characterized by uneven ventilation in relation to blood flow, should have been abolished by oxygen inhalation.

It is generally accepted that demonstration of significant arterial oxygen unsaturation negates the clinical diagnosis of polycythemia rubra vera.[3,4,9,11] In a study of 13 patients with polycythemia rubra vera and nine with established secondary polycythemia, Fisher, et al.[9] found oxygen saturations varying between 93.4 to 100 per cent in those with the primary disease and values less than 93.4 per cent in all those with secondary polycythemia. When the two are noted to coexist, Rathroe and Comroe[12] have suggested that hypoventilation secondary to direct involvement of the respiratory center may be responsible. In others definite abnormalities in ventilatory functions may be observed.

Nevertheless, it is uncommon to find polycythemia rubra vera and arterial oxygen unsaturation in the same patient. We cannot relate the intense thrombocytosis, as found in this patient, to secondary forms of polycythemia. The pulmonary function studies as obtained in this patient were not striking (Table 2). The increase in residual volume is significant, but compatible with changes of senile emphysema, and is not felt to be of clinical significance.

The inability to obtain complete arterial oxygen unsaturation suggested a functionally significant arteriovenous shunt. However, no anatomic shunts were demonstrable during the patient's protracted hospital course or at postmortem examination. The failure to obtain full saturation remains an enigma.

Ante-mortem diagnoses of primary central nervous system neoplasms occurring in the course of polycythemia rubra vera are extremely difficult. In this patient attention ultimately focused on a space-occupying lesion demonstrated in the carotid angiogram (Fig. 2). The neurologic deficits and the electro-

TABLE 3. *Arterial Blood Study — October 17, 1958*

| | NORMAL | $LBA_1$ REST | $LBA_2$ $O_2$ Inhalation Mask 7 L/Min-10 Min |
|---|---|---|---|
| $O_2$ Capacity Volume % (Beckman) | 18.5-20.4 | 27.79 | 27.90 |
| $O_2$ Content Volume % (Van Slyke) | 17.7-20.4 | *23.49 | *24.91 |
| $O_2$ Saturation % | 95 - 98 | 84.5 | 89.3 |
| pH | .... | 7.44 | 7.44 |
| Hemoglobin Gm/100 ml. | 14 - 16 | 20.7 | 20.8 |
| $CO_2$ Content Volume % | | 39.82 | 42.03 |

* 0.25 cc. $O_2$ subtracted for dissolved $O_2$

TABLE 4. *Arterial Blood Study — December 11, 1958*

| | NORMAL | $LBA_1$* | $LBA_2$† | $LBA_3$‡ |
|---|---|---|---|---|
| $O_2$ Capacity Volume % (Beckman) | 18.5-20.4 | 23.80 | 23.80 | 23.80 |
| $O_2$ Content Volume % (Van Slyke) | 17.7-20.4 | 21.20 | 22.26 | 22.96 |
| $O_2$ Saturation % | 95 - 98 | 89.1 | 93.5 | 96.5 |
| pH | .... | 7.45 | 7.47 | 7.44 |
| Hemoglobin Gm/100 ml. | 14 - 16 | 17.8 | 17.8 | 17.8 |
| $CO_2$ Content Volume % | .. . | 44.64 | 42.07 | 46.00 |

* Rest
† Effort (10 minutes) Leg Raise
‡ $O_2$ Inhalation Demand (10 minutes)
Note: No correction made for dissolved $O_2$

encephalogram were compatible with a space-occupying lesion.

Conversely, the relationship between primary central nervous system neoplasms, particularly infratentorial vascular tumors, and erythrocytosis of the peripheral blood has been apparent for a number of years.[6,7,13] Holmes, et al.[13] in 1952 reported two cases of primary brain lesions accompanied by a significant erythrocytosis, and showing arterial oxygen unsaturation. In one, there was improvement in oxygen saturation from 84 to 91 per cent following oxygen therapy, but complete saturation was not obtained. Ventilatory functions and numerical platelet counts were not available on these patients. These authors suggested simple hypoventilation, related to the depression of the respiratory center, by increasing intracranial pressure, as causal. Nineteen cases of central nervous system neoplasms, associated with erythrocytosis, were reviewed by these authors. Eleven of the nineteen neoplasms were described as vascular and twelve subtentorial in location. Incidentally, papilledema is described frequently in these patients with central nervous system neoplasms and erythrocytosis.[7,13,14] It should be noted that leukocytosis, and especially thrombocytosis, are not described as concomitant findings in the usual course of these tumors. As has been described, surgical removal of the vascular neoplasm may be followed by return of the hemogram to normal values.[8,14]

The hypophyseal-hypothalamic system has been incriminated in the pathogenesis of these varieties of erythrocytosis but no specific humoral and/or erythropoietic substance has been isolated.[8,15,16] One might suggest that the deterioration of the hemogram, noted in this patient postoperatively, might reflect surgical ablation of the central nervous system neoplasm; however, excision of the neoplasm was incomplete, and the postoperative course was probably too short to make such a suggestion tenable.

Thus, it is felt there is no adequate physiologic explanation for this patient's significant erythrocytosis, leukocytosis, and thrombocytosis. It is suggested, then, that this patient had polycythemia rubra vera with unassociated arterial oxygen unsaturation of unknown origin, and with an unrelated glioblastoma multiforme, presenting in the left temporal lobe.

## Summary

1. A patient is reported, who initially presented with evidence of erythrocytosis, leukocytosis, and thrombocytosis compatible with polycythemia rubra vera.

2. Significant arterial oxygen unsaturation, clinically suggestive of an arteriovenous shunt, is described. The failure to demonstrate a reasonable explanation for the arterial oxygen unsaturation is noted. Attention is called to utilization of arterial blood gas studies in differentiating primary and secondary forms of polycythemia.

3. A glioblastoma multiforme involving the left temporal lobe was diagnosed at ante-mortem craniotomy. The suggested relationship between vascular central nervous system neoplasms and simple erythrocytosis is noted.

4. It is suggested that the entity of polycythemia rubra vera, arterial oxygen unsaturation, and glioblastoma multiforme, as presented in this patient, were unrelated.

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SODIUM IN DRINKING WATER. — Physicians should be alert to the possibility that ordinary drinking water may contain large amounts of sodium in tasteless form. The sodium content is often high in water from private wells that fill by lateral seepage through soils, and much of this sodium is in the form of sulfate or nitrate, which is more difficult to recognize by taste than is sodium chloride. The sodium content is likely to be low in river water composed of surface rain water from mountains. — ABSTRACT: *Circulation,* 23:562-566 (April) 1961.

# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT P. CARSON, M. D., *President*

PRESENTATION OF CASE

PRESENT ILLNESS: This 47 year old male Negro was admitted to the University Hospital for the first time with a four-day history of nausea and vomiting. The vomitus consisted of food and bitter material. He had not had a bowel movement since the onset of his illness, and he could not recall passing flatus. He denied abdominal pain, previous change in bowel habits, fever, chills, or tarry stools. Three days prior to admission he developed constant eructation, and he was seen by a private physician who prescribed Diuril®, and Compazine®.

### Past History

One year prior to the present illness this man was admitted to another hospital and treated for "congestive heart failure and pneumonia." He had been on a digitalis preparation since that time. There was no history of hypertension, rheumatic fever, or syphilis.

The patient stated that he had consumed one pint of whisky daily for as long as he could remember. He denied coma, jaundice, or ascites in the past. He had no known allergies.

### Physical Examination

The blood presure was 130/80, pulse rate 92 per minute, respiratory rate 22 per minute, and temperature 98.2°F. The patient was an obviously ill, obese Negro man who was constantly eructating. His scleras were questionably icteric. Neck veins were flat, and the chest was clear except for occasional fine rales in the bases. His heart rhythm was normal with occasional premature contractions. The heart was enlarged to the anterior axillary line with a grade 2 harsh systolic murmur. The abdomen was grossly distended and tympanitic. Bowel sounds were absent with occasional tinkles. There was no fluid wave or rebound or referred tenderness. Rectal examination showed an empty ampulla.

### Laboratory Data

On admission the hemoglobin was 14 Gm. per 100 ml., hematocrit 40 per cent, white blood cell count 9600 per cu. mm. Serum amylase was 91 units. Sodium was 133, potassium 4.2, chlorides 95, and $CO_2$ 24 mEq./L.; icterus index was 36, blood urea nitrogen was 49 mg./100 ml. On the first hospital day the amylase rose to 483 units and the icterus index to 50; his white blood cell count rose to 14,975/cu. mm., with severe toxic granulation of the leukocytes. A sickle cell preparation was negative. His reticulocyte count was 1.5 per cent. On the second hospital day the alkaline phosphatase was 5.2 units; amylase 336 units, and icterus index 100; direct bilirubin was 12, total bilirubin 19 mg./100 ml. His blood urea nitrogen was 83 mg./100 ml. On the third hospital day the blood urea nitrogen was 12 mg.; $CO_2$ 30; calcium 4.4 mEq./L., amylase 202 units; direct bilirubin 27, total bilirubin 38.1 milligrams.

The chest x-ray taken on admission showed questionable cardiomegaly and underaeration of the base of the left lung. Flat and upright abdominal films were interpreted as showing either mechanical large bowel or mechanical small bowel obstruction.

### Hospital Course

Upon admission the diagnosis of large bowel obstruction due to carcinoma of the colon was made. Electrocardiogram showed frequent ventricular premature contractions and evidence of an old posterior infarct. Five hours after admission the patient was taken to surgery and an exploratory laparotomy was done. No definite cause of obstruction was found, and specimens for biopsies were taken of the liver, ileum and mesentery. The liver showed fatty infiltration. The ileum showed submucosal interstitial hemorrhage; the mesentery showed areas of fat necrosis. Two hours after surgery his pulse rate

*Presented by*

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Edited by Dr. von Haam.

Submitted April 27, 1962.

rose to 120 per minute, and his blood pressure dropped to 90° systolic. He was started on vasopressors and during the next 24 hours (his first hospital day) he was given 4 units of plasma and 1 unit of whole blood. He was digitalized and treated with penicillin, streptomycin, oxygen, and positive pressure breathing.

The patient's urinary output remained over 30 cc. per hour during his first and second hospital days. Early on his second day his temperature rose above 102° and remained above 102° until his death. His pulse rate rose above 110 beats per minute and remained so until his death. During his second hospital day his blood pressure remained hypotensive despite 3 more units of plasma. During the patient's entire postoperative course his jaundice deepened and he continued to have abdominal distention. On his third hospital day he received 1 unit of blood and 1 unit of plasma. A repeat electrocardiogram showed a fresh myocardial infarct. His respirations rose to over 40 per minute, and his urinary output dropped to 10 cc. per hour. Late in the evening his respirations quietly ceased and he could not be revived despite vigorous therapy.

## CLINICAL DISCUSSION

DR. HOLDEN: Fundamentally, this was a 47 year old man who had been presumably in good health until four days before he was admitted to the hospital. He had had only one illness in the past, approximately a year before admission when he was admitted to another hospital and a diagnosis of congestive heart failure with pneumonia was made. In a 47 year old man the first thing you would wonder about is why he had congestive failure, and we learn that he had never had a history of hypertension, rheumatic fever, or syphilis. At this age it would be unlikely that he would develop congestive failure as a result of any congenital heart disease. So you begin to wonder whether this patient had artiosclerotic heart disease with coronary thrombosis. Although this is somewhat unusual at 47, it is perfectly possible.

Before he was admitted to the hospital he developed nausea and vomiting, and the vomitus consisted of food and bitter material. One of the things that is of great importance in arriving at a diagnosis in any patient who has ben vomiting for four days is to know as precisely as you can the nature of the vomitus. The bitterness of his vomitus might have represented hydrochloric acid from the stomach, or bile, and often one can examine the vomitus and question the patient more carefully and decide whether you are dealing with a pyloric obstruction or some disorder of the intestinal tract distal to the pylorus. With all this vomiting that he had, he had had no abdominal pain or any previous gastrointestinal symptoms, which is of some significance for the differential diagnosis. Then we have the fact that this man had been drinking a pint of whisky daily for as long as he could remember. Again this may be of significance in the differential diagnosis of the present illness.

When he was admitted his vital signs were reasonably normal except for the tachycardia. In the protocol it states that he was an obviously ill man who was constantly eructating, and you wonder why he was "obviously ill." His scleras were questionably icteric. It is often difficult to recognize jaundice in a patient, especially in a Negro patient. His neck veins were flat. This is an important observation not only in terms of his past history but some of the events that occurred subsequently. His rales over both lung bases may be associated with some lesion of the heart or they may be associated with some intra-abdominal condition that is partially immobilizing the diaphragm and producing atelectasis at the lung bases.

### Not Mechanical Obstruction

The observation that his abdomen was greatly distended and tympanitic is of some importance, I think. The interpretation of absent bowel sounds is somewhat difficult. The mere statement would imply that perhaps this patient did not have a mechanical intestinal obstruction even though he was greatly distended and had a history of persistent vomiting over a period of four days. His rectal examination showed an empty ampulla, again strongly suggesting that we are dealing with some form of intestinal obstruction.

His laboratory data are of considerable interest. This is a patient who has been vomiting for four days and presumably is dehydrated, and some of the laboratory determinations that follow support this suggestion. However, his sodium was very low for a dehydrated patient, his chlorides were also somewhat reduced, and his icterus index was elevated. He had a moderate acidosis, and his blood urea nitrogen was elevated. Whenever we see a blood urea nitrogen of 49 in a patient who has been ill for four days we have to start wondering whether he has pre-existing renal disease with some degree of azotemia, or whether this azotemia represents a prerenal type of lesion — that he is essentially dehydrated and this accounts for the elevation of the BUN. The fact that the patient was not ill prior to four days ago suggests strongly that we are dealing with a phenomenon of acute dehydration.

On his first hospital day his amylase rose significantly, indicating some of the things we have to consider seriously in the differential diagnosis. His icterus index was going up rather abruptly and his white blood cell count was now elevated. A normal alkaline phosphatase in the presence of an acute icteric condition makes one always wonder whether we are dealing with a hemolytic process, although we have no indication that he was hemolyzing. The next day his amylase started falling while his icterus index rose to 100 and his blood urea nitrogen went

up to 83, indicating perhaps even further dehydration. At this time we have a direct bilirubin of 12 and total of 19, indicating that we are very likely dealing with some form of obstructive jaundice. On the third day his BUN was back to normal and his amylase continued to fall.

Now at the time of admission everything suggested very strongly that we are dealing with a patient who had some form of intestinal obstruction and I think the x-rays that were taken at the time suggested, according to the protocol, a mechanical large bowel or a mechanical small bowel obstruction. I wonder if Dr. Cook will comment upon these x-rays?

### Discussion of X-Ray Studies

DR W. T. COOK: The chest film shows an elevated diaphragm with compression of the lung bases. In the abdominal films the distention that was obvious in the chest film is seen again, with many air/fluid levels on the upright film. In the recumbent film there are many coils of what in part, at least, is obviously small bowel. However, I regard some of these distended loops as hepatic flexure of the colon with a fluid level in it, and the coupling of coils of distended ileum with large bowel is strongly in favor of mesenteric vascular disease, and with the pattern of small bowel as it is, I would think it involved the superior mesenteric artery.

DR. HOLDEN: May I ask you another question about these x-rays? There has been described in acute pancreatitis a radiographic picture not dissimilar to this, where the transverse and right colon are distended together with small bowel distention —actually probably representing a combination of paralytic ileus as the result of peritonitis with a certain amount of interference with peristalsis in the transverse colon as a result of edema of the transverse mesocolon and edema around the transverse colon.

DR. COOK: I know what you are referring to. We have seen this picture a few times. In the ones I have seen the transverse mesocolon was quite thick and that was the tip-off. I don't see that here, so I would not be able to make this diagnosis.

DR. HOLDEN: Because of the strong possibility of intestinal obstruction this patient was prepared for surgery fairly promptly. He was operated upon five hours after admission and there was no obstruction found. Biopsy specimens were taken of the liver, the ileum and the mesentery. The liver showed fatty infiltration. This is of some importance because by this time we are all aware of the fact that the patient is jaundiced, and we have to start thinking about the differential diagnosis of this jaundice —whether it is hemolytic in origin, whether it is the result of hepatic disease, or whether this is obstructive jaundice. The fact that the liver showed nothing but fatty infiltration suggests that we are not dealing with an acute overwhelming hepatitis or with a drug intoxication. It agrees with the story that this patient had been drinking a pint of whisky daily for several years.

There was a submucosal interstitial hemorrhage in the ileum. This may be of some importance and it may not be. Subserosal hemorrhages are not uncommon in a variety of conditions, but submucosal hemorrhage is something different, and one of the things that we would be thinking about at this particular time is whether we are dealing with some obstruction to the venous outflow from the small bowel that has led to multiple hemorrhages within the wall of the intestine, or whether we are dealing with arterial occlusion where hemorrhage into the wall of the intestine eventuates sooner or later. We can't say at the present time.

### Fat Necrosis

The mesentery and the peritoneum showed areas of fat necrosis. Under what circumstances will we see fat necrosis in the peritoneal cavity? These are two relatively common conditions. One is in acute pancreatic necrosis, where fat necrosis, as you know, is characteristic of this disease. The other situation in which it is seen, not commonly but occasionally, is in a perforation of the duodenum, where a large amount of activated enzymes escapes into the peritoneal cavity and fat necrosis results if the situation exists for a long enough period of time. In fact, the highest amylase determinations that I have ever seen in the blood stream have been in patients with perforation of the duodenum and not in patients with acute pancreatic necrosis. However, it is awfully difficult for me to think in terms of a perforation of the duodenum in this particular patient since he had no abdominal pain and patients who perforate the upper part of their gastrointestinal tract invariably have pain unless they have a disease of their central nervous system.

The patient did not do well after surgery. He developed hypotension and tachycardia. He was given large quantities of plasma and one unit of blood on the first day. He was digitalized and given antibiotics, oxygen, etc. I would suspect from the fact that he was given the oxygen and the positive pressure breathing that he had some respiratory complication. He was undoubtedly coughing and because of the elevated diaphragm was not aerating properly. His urinary output remained adequate. His temperature rose and remained elevated until death. During his second hospital day his blood pressure remained hypotensive despite 3 more units of plasma. The mere fact that this patient received so much plasma in this hospital suggests very strongly that perhaps this patient had acute pancreatic necrosis. This is not a very good line of reasoning to take but nevertheless one would suspect that this was the situation. His jaundice deepened and he continued to have abdominal distention. On his third hospital day he had a fresh myocardial infarct

which I presume contributed considerably to his ultimate death.

We are faced now with a patient who was reasonably well, had a short history of vomiting, came into the hospital, developed obstructive jaundice with some evidence of fat necrosis, had a rise and fall in his serum amylase levels, and in spite of very vigorous therapy died. The films do suggest that this patient had some interference with the circulation of his arterial or venous mesenteric system. It is awfully difficult to tie some of these things together, but one of the things that I think we have to consider very seriously is that this patient was jaundiced when he came into the hospital. Many of these other events developed presumably subsequent to the time of admission.

### Why Jaundice?

Why was the patient jaundiced? There are many reasons. In a patient of this age the most likely cause of obstructive jaundice is biliary calculi. About 60 per cent of all patients who become jaundiced after the age of 30 will do so as a result of stones in the biliary tract. About 10 to 15 per cent will become jaundiced as a result of cancer. One could quite easily postulate that he could have biliary calculi even though they did not cause any pain, and that he impacted a stone into the ampulla of Vater and that this led to all the subsequent events that occurred—a rapid rise of the serum bilirubin, the development of acute pancreatic necrosis as the result of a common channel existing in this particular patient. It is very unusual to see jaundice develop as intensely and rapidly as it did in this patient without there being some sudden complete obstruction to the flow of bile from the extrahepatic biliary tract. Stones will do this more than any other lesion. Occasionally a cancer in the vicinity of the ampulla will have bleeding into it and produce sudden complete obstruction, but this is very unusual.

Some patients who develop sudden pancreatic necrosis will become jaundiced for two reasons: They will hemolyze their red blood cells and jaundice may be apparent clinically as a result of intense hemolysis. They also may become jaundiced because of marked edema and necrosis, and sometimes the formation of an acute pseudocyst in the head of the pancreas with impingement upon the common duct may result in obstructive jaundice. Rarely, however, will the bilirubin rise as rapidly as it did in this patient, nor will it rise to these heights merely as a result of pancreatic inflammation or necrosis in the head of the pancreas. So I am left, I am afraid, with the strong suggestion that we are dealing with biliary tract disease in this patient, biliary calculi, a common duct obstruction, acute pancreatic necrosis, and the possibility that he had thrombosed his superior mesenteric vein to account for some of the manifestations that we see in this individual.

Dr. Zollinger: I think Dr. Holden has done a beautiful job of covering all aspects of the case presented here. I was saying a moment ago that I thought the patient was operated upon a little on the fast side. In a man who presented an x-ray that could not be interpreted as to whether it represented mechanical or paralytic ileus, you might be inclined to order a barium enema to make sure. You see no evidence of calcification in the pancreas? I admit that when they operated and found no obstruction, that was a little discouraging, but they discovered fat necrosis and I would think that would point to pancreatitis, and certainly the subsequent course of events would agree with it unless he developed gangrene of the bowel some place.

### CLINICAL DIAGNOSIS

1. Obstructive jaundice due to common duct stones.
2. Acute pancreatic necrosis
3. Possible superior mesenteric vein thrombosis.

### PATHOLOGICAL DIAGNOSIS

1. Severe arteriosclerotic heart disease.
2. Acute and chronic pancreatitis with fat necrosis.
3. Jaundice secondary to acute pancreatitis.
4. Venous infarction of the small bowel.

### PATHOLOGICAL DISCUSSION

Dr. von Haam: At autopsy the body appeared well developed and well nourished. The skin showed marked icterus, as did the scleras and conjunctivas. There was a recent surgical incision and a gastrostomy opening. The peritoneal cavity contained a small amount of serosanguineous fluid. The peritoneal surfaces were injected and foci of fat necrosis could be noticed scattered throughout the entire peritoneal cavity. The heart weighed 400 Gm. and showed an increased amount of fat deposits in the pericardium. The posterior wall of the left ventricle showed extensive scarring with thinning of the wall and areas of yellowish necrosis. In addition, small reddish-brown hemorrhagic areas could be noted suggestive of an acute infarction. The coronary arteries showed severe arteriosclerosis with complete occlusion of the right coronary artery for a distance of approximately 7 mm. The occluding material appeared to be both old and fresh. Both lungs showed small foci of bronchopneumonia in the lower lobes.

The liver was enlarged and showed grossly fatty infiltration. The gallbladder contained 40 cc. of viscid greenish-yellow bile without stones. The common bile duct was moderately distended but no obstruction was noted. The pancreas was swollen and showed extensive areas of edema, hemorrhage and fat necrosis. The mesenteric arteries appeared patent. Some of the loops of bowel appeared extremely congested and had a dusky bluish-red discoloration. The lumen of the bowel, however, contained only greenish-yellow mucoid material. The

kidneys were enlarged and icteric. The surface was smooth and the cut surface revealed considerable edema.

### Microscopic Examination

Microscopic sections revealed rather extensive myocardial infarction which for the most part appeared old, showing the myocardium replaced by fibrosis. Some of the areas surrounding the scar tissue showed evidence of more recent infarction with some leukocytic infiltration. The changes also involved the conductive fibers beneath the endocardium. The right ventricle showed considerable infiltration by fat tissue. Sections of the coronary arteries revealed an old thrombus with recent hemorrhage in the wall of the right coronary artery. Sections through the liver showed fatty changes. There was no evidence of hepatitis or obvious biliary obstruction. There were numerous small petechiae in the mucosa of the stomach and the wall of the small intestine showed patchy areas of hemorrhagic infarction. There was no evidence of mucosal necrosis or hemorrhage into the lumen, which suggested venous obstruction rather than arterial thrombosis. All areas of fat necrosis appeared rather recent and were particularly extensive in the parapancreatic region. Examination of the pancreas showed not only acute inflammatory changes but also diffuse fibrosis, suggesting a previous chronic pancreatitis.

From the findings at autopsy we can undoubtedly conclude that the patient was suffering from arteriosclerotic heart disease with old and probably more recent infarctions. We also can state that the patient suffered from chronic pancreatitis with acute recent exacerbation leading to rather extensive necrosis. The patient's jaundice was probably partly hemolytic, partly due to obstruction of the common duct by the swollen pancreas—the possibility suggested by Dr. Holden. The other possibility, that the patient had a stone in his common duct which passed and therefore was not found, cannot be ruled out. The infarction of the small intestine must be explained as a result of capillary stasis since no arterial or venous thrombi were found. This could be explained by shock and falling blood pressure.

The problem is to decide whether his pancreatitis aggravated his arteriosclerotic heart disease or whether his arteriosclerotic heart disease played any contributory role in his pancreatitis. Both conditions undoubtedly existed before the patient became acutely ill. It is my feeling that the two conditions probably existed independently. The patient's death was caused by shock due to the pancreatitis and the surgical trauma which aggravated his already much embarrassed coronary circulation and which caused the prerenal azotemia which was present at the patient's death.

### Closing Comments

DR. HOLDEN: I am certain that this patient's disease process cannot be explained as a single entity. I do think we see patients with acute pancreatitis and peritonitis developing thrombosis of the small mesenteric veins. There are many studies that suggest there is at least a coincidental relationship of some significance between biliary tract disease, pancreatitis, and coronary artery disease, but I do not know of any direct relationship with the exception of the well-known one between biliary tract disease and pancreatitis.

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THE EFFECT OF MEAL EATING VERSUS NIBBLING was studied in comparable groups of chickens. They were fed various diets conducive to the production or regression of atherosclerotic lesions and were allowed to eat at discrete intervals (2 one-hour periods daily) or ad libitum (24 hours daily). The induction experiments showed that meal eaters exhibited twice the serum cholesterol levels and 7 times the severity of coronary atherosclerosis seen in nibblers. In studies to examine the effects of the two eating habits on regression of established atherosclerosis, lesions were induced in the usual manner by feeding an atherogenic diet under the conditions of meal eating. The chickens were then put on regular mash and divided into meal-eating and nibbling groups. By comparison with the outcome with nibbling, meal eating of this regular diet was associated with a slower rate of decline in serum cholesterol levels to normal with a markedly decreased rate of healing of coronary lesions. Thus the manner of ingestion of a diet had a significant role both in accentuating the production and in inhibiting the regression of experimental atherosclerosis. — *Abstract:* Clarence Cohn, M. D., Ruth Pick, and Louis N. Katz, Chicago: *Circulation Research:* 9:139-145 (January) 1961.

Heart Page

# Recent Advances in Cardiovascular Pathology

SIMON KOLETSKY, M. D.*

ACCORDING to recent data from three large medical centers widely separated geographically, the only difference in sex ratio of acute myocardial infarction at autopsy is found below the age of 50 years. Even in this younger age group the difference in incidence between men and women (2.8 to 1) is less than the overall difference in incidence for all age groups as given in standard medical texts. The autopsy incidence of acute myocardial infarction is equal in men and women past 50 years of age. Thus, as a general trend, the epidemiologic characteristics of acute myocardial infarction in autopsy series are changing.

The only striking difference in the incidence of acute myocardial infarction between the two sexes is found in the patients discharged alive. Here the overall incidence in men was 3.5 times that in women, but when only patients under 50 years of age were considered the ratio of men to women was 12 to 1, as compared to 2.8 to 1 among the autopsied patients in the same age group and 2.2 to 1 among patients discharged dead with only a clinical diagnosis. This suggests that the disease is more likely to be fatal in women and/or that the diagnosis is less obvious in young women than in men, perhaps because of the possibility that the diagnosis is not often entertained in young women.

## Arteriosclerotic Heart Disease

The nomenclature and criteria of the New York Heart Association state that the diagnosis of coronary artery disease rests in part on the finding of abnormal physical signs indicating arteriosclerosis of the aorta. This implies that there is a positive correlation between the presence of arteriosclerosis of the aorta and stenosing arteriosclerosis of the coronary arteries. The validity of this assumption was tested by comparing the appearance of the thoracic aorta as seen on an x-ray film shortly before death with the degree of stenosing coronary arteriosclerosis noted at autopsy. *No valid correlation was found.* This indicates that roentgenographic evidence of arteriosclerosis of the thoracic aorta, whether calcification (intimal atherosclerosis) or enlargement (medial arteriosclerosis), does not constitute an accurate basis for the diagnosis of coronary arteriosclerosis. X-ray evidence of arteriosclerosis of the aorta is not an accurate way of judging the state of disease of the coronary arteries.

Evidence has been offered that there is no significant difference between diabetics and nondiabetics in the degree of extramural (large vessel) coronary arteriosclerosis when the factors of age, sex, and hypertension are properly assessed. However, diabetics show much more severe proliferative and hyalinizing lesions of the smaller intramural branches of the coronary arteries than do nondiabetics. This difference may explain the increased frequency of myocardial infarction in patients with diabetes.

Autopsy studies of 123 patients with cirrhosis of the liver revealed coronary occlusion with myocardial infarction in only 3.3 per cent. This compared with an incidence of 11.4 per cent in the general autopsy population. This reduced incidence cannot be explained entirely on the basis of malnutrition. Other factors which probably diminish the incidence of coronary atherosclerosis in cirrhotics are (1) lower cholesterol levels, (2) increased function of fat-clearing factor (lipoprotein lipase), and (3) heightened estrogen titer.

Extensive myocardial necrosis and subsequent scarring of the heart can be produced in rats by simultaneous administration of corticoids and sodium salts such as a sulfate or chlorate. The lesions have been designated as electrolyte-steroid cardiac necrosis and their production in this manner suggests that cardiac muscle contains a labile chemical system. The results suggest the possibility that certain types of myocardial necrosis in man, i. e. isolated myocarditis, the toxic myocarditis, and acute infections like diphtheria and typhus, and cardiac infarct unassociated with coronary artery disease, might have their origin in this manner.

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The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association. —Ed.

*Dr. Koletsky, Cleveland, is professor of pathology, Western Reserve University School of Medicine, and Chairman of Research Review Committee of Ohio State Heart Association.

# Maternal Deaths Involving Criminal Abortion

## With Comment of Consulting Medicolegal Examiner

By the OSMA COMMITTEE ON MATERNAL HEALTH

WE REALIZE that an accurate figure on the true incidence of criminal abortion may never be obtained; practically the only statistics available concern patients who die following careless, illegal procedures. Herewith the Committee presents three cases of alleged criminal abortion, with a varied assortment of facts associated with each death. One patient was separated from her husband while two were married. The method employed in an attempt to terminate the pregnancy was revealed in only one case, although another patient sustained a perforated uterus; in no case do records indicate investigation by the coroner. All three cases represent tragic death resulting from overwhelming sepsis.

### Case No. 502

This patient was a 22 year old Negro, Para I, abortus I, who died 21 days following alleged criminal abortion.

Past history was not remarkable, including one term pregnancy two years before. With a last menstrual period January 14, the present history shows one prenatal visit at eight weeks' gestation (March 15), at which time the patient was extremely unhappy about the pregnancy. She was admitted to the hospital about two weeks later on April 4, extremely septic and mildly delirious, with a story suggesting self-induced abortion approximately one week prior to admission. Subsequently, she developed abdominal pain and fever. In the hospital she was given supportive treatment, including massive multiple antibiotics.

Her course in the hospital was characterized by fever, chills, acute abdominal pain, purulent vaginal discharge, and scant vaginal bleeding. She continued to deteriorate, clinically, in spite of therapy. Medical and surgical consultation advised waiting for fluctuation and drainage from below, but in face of a deteriorating condition a supracervical hysterectomy and left salpingo-oophorectomy was done April 10, through an acutely inflamed pelvic mass. The lungs were "clear" before surgery. Cardiac arrest occurred one hour after surgery and a cardiac massage was performed, but the patient did not respond. More recent information revealed bloody fluid was obtained by suction through the intratracheal tube at the time of cardiac massage, when the apparatus was finally available. She died April 10, at 12:00 p. m. An autopsy was permitted.

*Pathological Diagnosis:* Atelectasis of lungs, 65 per cent; acute bronchopneumonia; septic splenitis; suppurative pelvic inflammation with abscess and venous thrombosis; albuminous degeneration of liver and kidneys; local necrosis of liver; acute pyelonephritis, local. Septicemia due to infected incomplete self-induced abortion.

### Comment

The Committee voted this a preventable maternal death, with the patient primarily responsible. Several members questioned the desirability of the laparotomy. It was pointed out that Falk advised early immediate and radical surgery as a lifesaving measure; his cases all predate the antibiotic era. Members questioned whether or not a blood culture was done to isolate the causative organism. These details, together with other laboratory findings, were not recorded.

### Case No. 557

This patient was a 33 year old, white, gravida V, Para III, abortus I, who died undelivered at 14 weeks' gestation.

The past history was not pertinent and was not remarkable, except for three uneventful pregnancies and one early uncomplicated abortion. Cervical polyps were removed four years ago.

Present history showed the patient to be at 13 to 14 weeks gestation; she had attempted to induce an abortion by inserting a catheter into the cervix and through it she instilled a mixture of 39 cc. U. S. P. heavy mineral oil, 1 cc. Bacterial Intravenous Protein (a type of organic iodine compound), ½ gram dihydrostreptomycin, 100,000 units of procaine penicillin and 100 mg. Terramycin®. Thirty minutes later she vomited iodine-tasting material. Subsequently, she developed pain in chest, dyspnea, cyanosis, and weakness; the vomiting continued. She was admitted to the hospital two days later (October 14) with the persistence of her chest symptoms, along with uterine cramps and bleeding. Her clinical picture, substantiated by x-ray, was that of acute pulmonary edema and a chemical pneumonia. She also had oliguria. The patient received intense supportive treatment, including sedation, antibiotics and oxygen, but died October 16 with anuria. An autopsy was permitted.

*Pathological Diagnosis:* Pulmonary edema; renal shut down; unaborted three months gestation in situ; endometritis and parametritis. Discharge diagnosis was "Infected criminal abortion."

### Comment

The Committee considered this a preventable maternal death, patient responsibility. Members noted that there was nothing in the history leading to the belief that the patient had any assistance in the procedure, therefore it was considered a purely self-induced abortion, and thereby not *fully criminal* in the legal sense. Furthermore, there was nothing in

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

the protocol which could not be explained on a purely chemical inflammatory reaction due to the substances introduced. It is not known how she arrived at the desired quantity of drugs to instill and the formulation of the mixture. There was nothing in the autopsy report which would lead members to the belief that the mixture was introduced directly into the blood stream. All symptoms could be explained on the basis of direct absorption of toxic substances. Most of the members felt extremely ignorant of the physiological and toxic effects of substances introduced into the uterine cavity.

### Case No. 577

This 25 year old white nullipara, was admitted to the hospital December 11, with abdominal pain, and died four days later.

The patient gave a history of starting a "menstrual period" December 8, several days before admission, and since then she had developed severe abdominal pain, excessive vaginal bleeding and temperature elevation. A family physician had given her pills and antibiotics. Her last *normal* period was in the beginning of November. She denied being pregnant.

On admission (December 11) her blood pressure was 112/68, temperature 102.4°, pulse rate 132 per minute, respiratory rate 28 per minute. Physical examination was negative, except for extreme lower abdominal pain, rigidity of abdominal muscle and extreme tenderness to the touch. She *refused* to allow a vaginal examination on admission! Admission urinalysis showed 2 plus albumin, 1 plus bacteria and 3 to 6 white blood cells. The leukocyte count was 17,000, hemoglobin 10.3, hematocrit 33 per cent. Massive doses of antibiotic were begun at once, in addition to tetanus antitoxin.

On the second hospital day she did not improve from her extreme state. Vaginal examination at this time showed thickened and tender adnexal areas, extreme pain on movement of cervix, bloody purulent discharge coming from the cervical os. Culture smears and antibiotic sensitivity tests were taken, and one unit of blood was given. Patient continued to be moribund.

On December 15, the abdomen remained distended, but pain and tenderness seemed less. She had begun to vomit the day previously. At this time muscle spasms of extremites were noted, along with hyperactive reflexes. She died the following day. Autopsy was permitted. (Her mother volunteered information that the patient "paid $200 to be aborted.")

*Pathological Diagnosis:* Traumatic perforation of uterus with purulent pelvic peritonitis and septicemia as evidenced by toxic degeneration of liver, adrenals, acute splenitis and mesenteric lymphadenitis; acute purulent endometritis with necrotic decidua and localized syncytial myometritis; acute hemorrhagic bronchopneumonia with bilateral hydrothorax. Ovary; "old corpus luteum of pregnancy" with marked hypertrophy of theca interna cells — marked luteinization.

### Comment

After prolonged deliberation, the Committee considered this a nonmaternal death feeling that there was *no specific evidence* of an existing pregnancy reported at autopsy, e. g., chorionic villi, etc. However, a "corpus luteum of pregnancy" was reported (?).

Members puzzled over the network of possible events which might lead through a thin fabric of facts available in the case. Finally, by a narrow vote, the case was listed as *"maternal death, preventable, fault of the patient."* The consulting pathologist submitted a belief that chorionic villi may have disappeared, especially had a greater length of time elapsed following the actual expulsion of products of conception; no date for this was ever established. Further, even if the patient *were not* pregnant, the apprehension, anxiety and intent (associated also with pseudocyesis) could logically predispose to the act which allegedly was performed on such grounds and led to eventual death. Therefore, the change in classification; the causative organism was not recorded. It adds up to a young woman having marital difficulties passing her expected menstrual period by several days and seeking the aid of someone to "induce abortion" followed by overwhelming sepsis.

### Comment of Consultant

The following comment of a consultant, a medical examiner who is an expert in medicolegal problems, was given at the request of the Committee:

"In the introductory paragraph the following statement appears as accepted fact: 'accurate figures on the true incidence of criminal abortion may never be obtained; practically the only statistics available concern patients who die following careless, illegal procedures.' The cases presented and the comments of the Committee illustrate the physicians' role as a crucial factor in obfuscating the true incidence of abortion.

"The primary dereliction of duty is inferred from the apparently consistent failure to notify either police or coroner of the suspicion of abortion. It is stated that 'in no case do records indicate investigation by the coroner.' Three possibilities can be inferred: Either these cases were reported and not investigated, or were investigated and not made a matter of record, or were never reported. If the cases were reported and not properly investigated by the coroner, it would seem that the coroner was at fault unless the report from the physician was incomplete, erroneous or misleading. Regardless of whether the coroner or physician was at fault, the lack of performance is in direct violation of the law. (See *Ohio Revised Code, Sec. 313, et seq.)*

"Comment of the Committee on the second case includes the following statement: '. . . . . therefore it was considered a purely self-induced abortion, and thereby not *fully criminal* in the legal sense.' In this misconception that self-induced abortion is not criminal lies another important factor influencing the obfuscation of the incidence of abortion. Induced abortions, unless for therapeutic reasons, are illegal. *(Ohio Revised Code, Secs.*)*

"It should be pointed out that in at least two of the cases cited there was suspicion that an accomplice was involved. Failure to report the circumstances and information to the police *before* death or to the coroner immediately at the time of death constitutes an evasion of the law and obstruction of justice. The

*Ohio Revised Code Abortion—2901.16 - 2901.17 Advertising drug for 2905.33 - 2905.34 Drugs, etc. to procure 2905.32 et seq. Dying declaration 2901.17 Search warrant for articles of 2905.35, 2933.21 et seq.

physicians usurped authority of legally constituted investigators and based their conclusions on assumptions rather than facts. Would these same physicians neglect to report a death to the coroner because they assumed that it was suicidal . . . 'and thereby not *fully criminal* in the legal sense'? Would they be equally noncommittal about suspicion of homicide? If so, then let them not blame the police and coroner for alleged undetected murders.

"Physicians should recognize that they have an awesome responsibility toward the effective administration of the official medicolegal authority. The Ohio statues concerning the coroner are acknowledged to be exemplary. Means are provided for penalizing persons who fail to inform the coroner of reportable deaths. However, laws alone cannot ensure full compliance. Physicians must realize that legal problems as well as medical problems must be resolved in every medicolegal death. Resolution of legal problems requires specialized investigations which differ in many respects from the medical investigations and do require full cooperation of the attending physician.

"If these cases had been referred to the police for investigation with the proper information, a discreet investigation might have disclosed pertinent details to aid the physician in diagnosis and treatment as well as affording the opportunity to implicate abortionists, accomplices and accessories to the crime.

"Although the number of fatalities have decreased due to the advent and use of antibiotics, it is generally acknowledged that there probably is an increase in the number of abortions induced illegally. As long as the criminal aspects of abortion are ignored by physicians the incidence will continue to increase. As stated above, certainly some of the reasons that accurate figures of incidence cannot be obtained is reflected in the vagueness or equivocation in the diagnoses in these cases and the lack of concern for the criminal aspects and their influence on the community and similar cases in the future.

"**Case No. 502:** The summary of this case acknowledges 'alleged criminal abortion' and 'a story suggesting self-induced abortion.' In the absence of reports of physical examination at time of admission and laboratory findings it must be inferred that the staff physicians neglected to identify the bacteria to guide selection of the most effective antibiotics and also raises doubt as to whether or not the patient received proper care at the earliest possible time.

"**Case No. 557:** Certainly more effort should have been exerted to determine how the patient obtained the formula for the mixture and whether or not she was advised to use this method for inducing an abortion. If the physician in charge of this patient knew this he was obligated to report this fact to the police *before* death and certainly, to the coroner as soon as death occurred. If a police investigation had been made more information would have been obtained, although in all probability it would not have prevented death.

"**Case No. 577:** In view of the history obtained and the condition of the patient, it is difficult to understand the acceptance of the refusal to allow a vaginal examination on admission. It would appear that the Committee is correct in considering this as a maternal death. The pathologic diagnosis must be considered in the light of the history and the time lapse following the apparent attempt at abortion. If the information volunteered by the mother that the patient paid 200 dollars to be aborted was not reported to the police and the coroner, this certainly constitutes an obstruction of justice. As in the other two cases, a definitive diagnosis as to the cause, mode and manner of death could not be made because of the apparent negligence in regard to obtaining a complete history, performing adequate physical and laboratory examination of the patient."

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TOXOPLASMA AND ABORTION. — Twenty to 25 per cent of fertile American women in their reproductive period have come into contact with *Toxoplasma*. Some of these transmit the infection to their offspring, with resulting abortions, stillbirths, and perinatal deaths. The frequency with which *Toxoplasma* produces abortion and fetal death has not yet been established. Figures of as few as 0.3 per cent to as many as 3 per cent of all abortions have been encountered. The problem merits further investigation. The methods chosen in the future can advantageously be based on isolation of the organisms from the fetus, or the placenta, umbilical cord, and fetal fluids, or from uterine fluids or tissue.

It will be of interest to determine how much *Toxoplasma* contributes to sterility through the causation of fetal death. An allied problem of particular interest will be to determine whether the poor breeding records of certain women with histories of repeated unsatisfactory pregnancies can be attributed to *Toxoplasma* infection. — D. Weinman, M. D., New Haven, Connecticut: Toxoplasma and Abortion: A Field for Further Investigation. *Fertility and Sterility*, 11/5:525-530 (Sept. - Oct. 1960).

# Presenting . . .

## The New President-Elect, Two New Councilors; With Information About Other Members of The Council

THE House of Delegates of the Ohio State Medical Association named a President-Elect and two new Councilors at the Annual Meeting in Columbus, May 14 - 18. Following are biographical sketches of these new officers and information about other members of The Council.

Dr. Horatio Thomas Pease, Wadsworth, was named President-Elect of the Association and will assume the Presidency at the 1963 Annual Meeting in Cleveland. Dr. Pease served three full terms as Councilor of the Eleventh District from 1954 to 1960 and presently is serving as an Alternate Delegate to the American Medical Association.

The life story of this Medina County general practitioner begins with a traditional American pioneer flavor. Dr. Pease was born in a log cabin on a modest farm along the Oconee River in Georgia. His father had gone South from Connecticut; his mother was from an old Southern family. Horatio was about six weeks old when his father went as a missionary to Norway where the family spent the next nine years in the land of the midnight sun. On returning to the United States in 1909, he attended school in Georgia, Tennessee, and finally in Ohio where he graduated from Minerva High School.

After serving in the Army during World War I, he pursued his education three years in Bethany College and one year in West Virginia University where he obtained his A. B. degree in 1922. He then married Miss Grace Campbell, of Peoria, Illinois, and spent the next four years teaching sciences in Point Marion High School, Pennsylvania, at the same time working toward a Master's Degree in chemistry.

In 1926, after his daughter Mary Lois was born, he entered Western Reserve University School of Medicine and received his M. D. degree in 1930, followed by an internship and residency in University Hospitals, Cleveland. Dr. Pease opened his practice in Wadsworth and has been there since, with time out for postgraduate work at Harvard, the University of Michigan, University of Buffalo, and military service again during World War II. He was released from military duty in 1946 with the rank of major after service as combat surgeon with the Fifth Army.

Dr. Pease is an active member of the Medina County Medical Society, having served as president, secretary-treasurer, and delegate. He has served as chief of staff at Wadsworth Municipal Hospital, and as a member of the Hospital Board. He is an associate member of neighboring Summit County Medical Society and a member of the American Academy of General Practice. Fraternal affiliations include memberships in Alpha Kappa Kappa, Phi Kappa Tau, Alpha Phi Epsilon (honorary literary) and Tau Kappa Alpha (honorary forensic).

Before being elected as Councilor of the Eleventh District, Dr. Pease for years served as a member of the State Association's Rural Health Committee, and among other appointments served on the OSMA Advisory Committee to the Woman's Auxiliary. Since 1958 he has been an Alternate Delegate to the American Medical Association.

Other affiliations include memberships in the Christian Church, the Rotary Club of which he is a past-president, the Masonic Lodge, American Legion and Veterans of Foreign Wars. Dr. and Mrs. Pease's son-in-law and daughter, Dr. and Mrs. David H. Stansbery, reside in Columbus. Dr. Stansbery earned his Ph. D. degree at Ohio State University and is teaching there in the Department of Zoology and Entomology. There are four grandchildren.



*Leaders of the Association are shown as the camera caught them during the Annual Meeting. Left to right, Outgoing President George W. Petznick, Cleveland; Incoming President George J. Hamwi, Columbus; and President-Elect Horatio T. Pease, Wadsworth.*

### Incoming President

Dr. Geo. J. Hamwi, Columbus, was installed as President of the Association at the Annual Meeting and will serve in that capacity through the 1963 Annual Meeting in Cleveland.

During his year as President-Elect, Dr. Hamwi followed a busy schedule in behalf of the Association. He visited many County Medical Societies, attended District conferences, appeared on radio and TV programs in behalf of the organization's policies.

As a physician-educator, Dr. Hamwi has been associated with Ohio State University College of Medicine since the end of World War II. He is now professor of medicine and director of the Division of Endocrinology and Metabolism in the Department of Medicine, and is director of the Clinical Metabolic Research Unit at the University.

His contributions to medical literature, particularly in the field of endocrinology, are numerous. His articles have appeared in top medical publications on national, international and local levels. As a lecturer he has addressed numerous audiences both professional and lay groups.

A native of New York City, Dr. Hamwi attended Columbia University for three years. Then, following a family tradition, he went to the American University of Beirut where he received his bachelor's degree in 1936 and his medical degree in 1940. Intern training followed at Metropolitan Hospital in New York and Presbyterian Hospital, Philadelphia.

With the entry of the United States in World War II, he joined the Navy and served as flight surgeon from early 1942 to July 1946, attaining the rank of lieutenant colonel. Residency work at Ohio State followed his return from military service and he received an additional M. S. degree after a residency in pathology.

In 1948 Dr. Hamwi returned to New York for a Fellowship in medicine in the Section of Endocrinology and Metabolism at Cornell and New York Hospital. On his return to Ohio State he was named assistant professor in the Section on Endocrinology and Metabolism. In 1958 he was named director of the Section and in 1960 was raised to full professorship with the added responsibility of directing the Clinical Research Unit.

As head of the Clinical Metabolic Research Unit, Dr. Hamwi directs a complex type of investigation delving into origins of a broad spectrum of diseases. Heads of key departments in the OSU College of Medicine serve on an advisory committee of this unit sponsored by the U. S. Public Health Service.

Dr. Hamwi's interest in medical organization work is indicated by his participation in more than a score of professional groups dedicated to the advancement of medicine and health. He early became a member of the Academy of Medicine of Columbus and Franklin County and the Ohio State Medical Association; also the American Medical Association. A diplomate of the American Board of Internal Medicine, he is a member of the local, state, American and International Societies of Internal Medicine.

He has served on the Council of the American

Diabetes Association and as a member of its committees on information and professional relations. He is a Fellow of the American College of Physicians, the American Geriatrics Society; member of the Endocrine Society, Central Society for Clinical Research, the OSU Institute of Nutrition and Food Technology, the Association of American Medical Colleges, Ohio Academy of Science, American Association for the Advancement of Science, the American Federation of Clinical Research, the New York Academy of Sciences, American Goiter Society, Central Ohio Heart Association, American Cancer Society, and the OSU Library Council.

Dr. Hamwi was elected Treasurer of the State Association in 1956 and was re-elected in 1958, and was named President-Elect at the 1961 Annual Meeting in Cincinnati. He previously served in the House of Delegates as delegate of the Columbus Academy. He has served the State Association in several other capacities and formerly was chairman of the OSMA's Committee on Scientific and Educational Exhibits. Dr. and Mrs. Hamwi are the parents of three sons.

### First District Councilor

The House of Delegates elected Dr. Robert E. Howard, Cincinnati, as Councilor of the First District. He succeeds Dr. Charles W. Hoyt, also of Cincinnati, who served two terms on The Council and was not a candidate for re-election.

Dr. Howard is a practicing physician in Cincinnati where he has been associated with a group of doctors specializing in otolaryngology since 1929. In the field of medical organization work he has been active, and for the 1960-61 season served as president of the Academy of Medicine of Cincinnati. Other offices include service in the OSMA House of Delegates.



Robt. E. Howard, M. D.

A native of Dayton, Dr. Howard began his college training at Ohio Wesleyan University, then continued at the University of Cincinnati where he received bachelor's degrees in both arts and sciences, later receiving his M. D. degree from the University of Cincinnati College of Medicine.

Graduate training took him first to the University of Pennsylvania and then to Europe where he studied at the University of Vienna. On his return to the University of Cincinnati and Cincinnati General Hospital, for continued studies in otolaryngology, he was named to the faculty, an appointment he has held since, now as assistant professor in the Department of Otolaryngology. Dr. Howard is a diplomate of the American Board of Otolaryngology and among professional associations is a member of the American Academy of Ophthalmology and Otolaryngology.

Dr. and Mrs. Howard are the parents of three sons, Dr. Robert E., Jr., now serving with the Navy Medical Corps; John, a student in veterinary medicine at Ohio State University, and William, a student at California Institute of Technology.

### Second District Councilor

Dr. George J. Schroer, Sidney, was elected to fill one year of an unexpired term as Councilor of the Second District. He succeeded Dr. Ray M. Turner, of Springfield, who resigned for reasons of health after serving three years in that office.

Dr. Schroer opened his office in Sidney in 1949 after serving with the Army Medical Corps during World War II. He has been in general practice there since. His interest in medical organization work is indicated by the number of offices he has held in that time. He is a past-president of the Shelby County Medical Society and served for ten years as Delegate of that Society to the State Association House of Delegates. In 1960 he was president of the Second District Medical Association.



Geo. J. Schroer, M. D.

Dr. Schroer is a native of the west-central part of Ohio. He was born at Coldwater in Mercer County. His college work was at Ohio State University where he received his bachelor's degree and his medical degree from the OSU College of Medicine in 1946. Internship followed at Miami Valley Hospital, Dayton. From 1947 to 1949 he served as medical officer with the U. S. Army, being stationed at the Base Hospital, Wright-Patterson Air Force Base.

Dr. Schroer has served as chief of staff at Wilson Memorial Hospital, Sidney, and for the past seven years has been a member of the Board of Trustees of Ottawa Valley Hospital, Lima. In 1946 he married Miss Mildred Hoying, a registered nurse who graduated from Good Samaritan Hospital, Dayton, The Schroers are the parents of four children, ages 9 to 15.

### Immediate Past-President

Dr. George W. Petznick, Cleveland, after serving as Councilor of the Fifth District then as President-Elect and President, will serve an additional year on The Council as Immediate Past-President. Dr. Edwin H. Artman, Chillicothe, relinquished this post at the Annual Meeting after nine years on The Council.

### Other Members of The Council

Dr. Philip B. Hardymon, Columbus, is serving a three-year term as Treasurer.

Dr. Floyd M. Elliott, Ada, was re-elected Councilor

# Officers, Councilors and Delegates Installed




*President Petznick, at the rostrum, has just called up newly elected and re-elected officers, Councilors and AMA Delegates shown here as they are presented to the House of Delegates.*

of the Third District. He was first elected to that office in 1958 and was re-elected in 1960.

Dr. Henry A. Crawford, Cleveland, was re-elected Councilor of the Fifth District. He was elected to that office in 1960.

Dr. Benjamin C. Diefenbach, Martins Ferry, was re-elected Councilor of the Seventh District. He was first elected to that office in 1960.

Dr. Chester H. Allen, Portsmouth, was re-elected Councilor of the Ninth District. He was first elected to that office in 1960.

Dr. Lawrence C. Meredith, Jr., Elyria, was re-elected Councilor of the Eleventh District. He was elected to that office in 1960.

Councilors in the midst of two-year terms are: Dr. Edwin R. Murbach, Archbold, Fourth District; Dr. Robert E. Tschantz, Canton, Sixth District; Dr. Robert C. Beardsley, Zanesville, Eighth District; and Dr. Robert M. Inglis, Columbus, Tenth District.

### Payment-In-Full Contract By OMI Authorized

ONE of the most important items of business transacted by the House of Delegates at the recent Ohio State Medical Association Annual Meeting in Columbus was the adoption of a resolution which authorizes Ohio Medical Indemnity, Ohio's Blue Shield Plan, to offer a payment-in-full indemnity contract to groups which qualify by certain income limits and when service is rendered by a voluntarily participating physician.

Ways to implement this will be considered at joint conferences between The Council of the OSMA and representatives of OMI scheduled for the near future.

For more details on this subject see Pages 807-808, Proceedings of the House of Delegates.

## Dayton Heart Research Center Planned

Developmental plans for a heart research center as an adjunct to the Charles F. Kettering Memorial Hospital in Dayton were reported in a recent issue of the *Dayton Daily News*. The center would be known as the Margaretta and James M. Cox Memorial Coronary Heart Institute. $650,000 has been pledged and a matching grant from the National Institutes of Health has been requested.

The center will be used for electronic research in the treatment of heart disease. General Electric Company will operate the electronic computer equipment.

The Kettering Memorial Hospital Center, where the institute will be located, is situated on Southern Blvd. between Stroop and Big Hill Roads. Target for completion of the $8.5 million hospital is mid 1963.

Dr. Douglas Talbot of Dayton has been designated medical director. Serving on the policy and liaison committee between the foundation and the Montgomery County Medical Society are Dr. T. L. Light, chairman; Dr. A. V. Black; Dr. Al Brust, associate medical director of the Cox Coronary Institute; Dr. John R. Keys, and Mr. Robert F. Freeman, executive secretary of the Society.

### Course in Gastroenterology

The Annual Course in Postgraduate Gastroenterology of the American College of Gastroenterology will be given at the Morrison Hotel in Chicago, November 1-3. Moderators for the Course will be Dr. Owen H. Wangensteen, chairman and head of the Department of Surgery of the University of Minnesota School of Medicine and Dr. I. Snapper, director of Medical Education, Beth-El Hospital, Brooklyn, New York.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, New York.

# President's Address . . .

## Presented May 14, 1962, Before the House of Delegates Of the Ohio State Medical Association, in Columbus

By GEORGE W. PETZNICK, M. D., Shaker Heights

MODERN medicine has become involved in all the crosscurrents of public interest, public opinion and political action.

If ever there was a time when both professional ethics and just plain human consideration counted, it is now.

Changes in medicine have forced physicians into adding a growing complexity of socio-economic matters to their traditional spheres of activity.

We have undertaken these new interests in the concern for efficient medicine.

We have accepted the need to study issues, arrive at decisions, and to make facts and opinions known to the public.

This is a constantly expanding activity, both in relation to specific problems, and to other health team members with whom we work.

We recognize the need for the best possible thinking and the greatest possible unity if we are to maintain our position of trust, responsibility and leadership in the medical affairs of the State of Ohio and of our nation.

### Many Dedicated People

With such a statement this House of Delegates, the doctors of Ohio and the people of Ohio must know that the Ohio State Medical Association is indeed an organization of many and its functions are the efforts of dedicated people.

Hundreds of committeemen have spent untold hours and energies in promoting the best in health care for the people of Ohio. They have helped other doctors, other medical organizations and other health agencies solve many problems.

To all of these, I want to express the appreciation of the Ohio State Medical Association.

### Able Helpers

I was blessed with two big men, big physically and big mentally.

Dr. Edwin Artman was ever ready to advise and cooperate. His sincere interest and friendship has been unfailing. His ability, knowledge and experience gained from many years of working in organized medicine will be an asset in our delegation to the AMA.

The other big man is our President-Elect, Dr. George Hamwi, a top educator in his field, is well known world-wide as a teacher and lecturer. His experiences have been of inestimable help to our Scientific Committee. His conscientious efforts on many committees and in our district meetings have served the Ohio State Medical Association well. His natural leadership will continue to serve medicine next year.

### Staff Praised

Many presidents of the OSMA have gratefully expressed their appreciation for our executive staff. The names of Nelson and Saville are known from coast to coast. The behind the scenes activities of our Columbus office have been a bulwark of strength to the doctors of this state and to the AMA. Our new staff man, Mr. Mike Traphagan is proving a wise choice.

Hart Page and Charles Edgar have become efficient, responsible work horses of this team and so I too, unhesitatingly want to add my sincere, heartfelt thanks to all of these men and to the staff in our office for helping to guide medicine through an untold maze of problems.

### Council Lauded

The OSMA has been very fortunate to have a thoughtful, hard working Council. These are certainly dedicated men. They have attended committee meetings, have given thought to the problems of the docket before council meetings and every district in the state has shown new, active interest in organized medicine. There is a uniting of efforts and a growth of understanding that has been the result of the work of your councilmen.

The constantly increasing work load presented to The Council and our committees by the House of Delegates, Councilor districts and allied health agencies does strain our budget. Our Treasurer, Dr. Hardymon has proved a capable advisor and manager of the finances of our organization. He is also a responsible addition to the workings of our Council

*The Ohio State Medical Journal* has received national attention because of the changing concept of

the functions of *The Journal*. The ideas and efforts of Dr. Perry Ayres as Medical Editor and Chuck Nelson as Managing Editor and Gordon Moore are being recognized in many areas of the country for developing improvements in spite of the difficulties presented by the problems of pharmaceutical advertisers.

I hesitate to call to your attention some of the important actions resolved this year because it is difficult to designate what is more or most important.

### New Annual Meeting Format

The Scientific Committee has been actively working since last summer to accomplish several things of note.

(1) A new format for the Annual Meeting which will bring nine of the specialty groups into our session promoting scientific programs for all of the doctors of Ohio and at the same time retaining their own identity with dinner and business meetings scheduled at the end of the week so that their members can attend with greater certainty.

(2) Many new scientific presentations including the famous Round Table Question and Answer Sessions on Thursday evening. Your presence at this innovation will be exceedingly profitable.

(3) One entire general session will be presented by the faculty of the Ohio State College of Medicine covering some of the top current medical subjects. Next year Western Reserve and then Cincinnati, will present similar programs.

### Committee on Radiation

A new Committee on Radiation was appointed. Radiation materials are being used extensively, not only by physicians, but also by industry. Regulation and control of such usage has been placed by legislation, under the Ohio Department of Health. The primary objectives of this committee are to help promote adequate and reasonable regulatory procedures governing the use of all radiation material and facilities and to educate members of the medical profession generally, on matters of radiation hazards.

The importance of such a committee should be obvious to everyone.

### Other Committee Activities

Our very active Committee on Maternal Health continues to broaden its reputation inside and outside of Ohio with its remarkable work. This type of activity is the prime objective of medical organizations and its educational work has the enthusiastic applause of the doctors of Ohio.

The Committee on Workmen's Compensation has successfully accomplished many changes of benefit to the doctors including the increase in the fee schedule that went into effect on January 1, 1962.

The Committee on the Care of the Aged with its Subcommittee on Home Care, in conjunction with 15 invited organizations, has successfully presented a model program for Home Care.

This program is the result of action of the House of Delegates at the 1961 meeting and it appears to have succeeded in accomplishing one of the first complete programs in the country.

It calls for a program centrally administered and which through coordinated planning, evaluation and follow-up procedures, provides for physician-directed medical, nursing, social and related services to selected patients at home.

It is hoped that this remarkable program will be put to use rapidly in many areas of the state for it




*Dr. George W. Petznick, of Cleveland, delivers the President's Address at the first session of the House of Delegates.*

can be a factor in solving some of the difficulties of bed shortages, hospitalization and health care costs.

Your Council has approved this program and commended the committee for the completeness of its work.

### Policy on Osteopathy

An official statement of policy was adopted by The Council on December 17, 1961 pertaining to ethical matters involved in professional relationships between doctors of medicine and doctors of osteopathy practicing in Ohio. The research and formulation of the statement were done by our excellent Judicial and Professional Relations Committee.

The complete text of this statement was sent to every physician in Ohio as part of an OSMAgram. It contained guiding principles for consideration and use by County Medical Societies in resolving this question locally.

The House of Delegates will be interested to know that last fall this was a topic of discussion in every district meeting in the state. The opinions expressed by many in these meetings were of benefit to The Council in their deliberations.

The efforts of our combined Committee on Educa-

tion, General Practice and Rural Health have been directed to the need for more family physicians. They have developed in detail a syllabus for the establishment and operation of a Family Practice Teaching unit for medical schools, also a Basic Program for the exposure of students to Family Practice concepts.

This very important program has received much favorable comment and expressions of deep interest from many areas of this country and from foreign medical centers as well.

The committee has had meetings with the Deans of all three of the medical schools of Ohio and is continuing in its efforts to secure more well trained and much needed family physicians.

### Additional Active Committees

Our Committee on Laboratory Medicine continues its instructional courses for technicians. Certainly all doctors and hospitals as well as the public stand to benefit much from more accurate and uniform laboratory procedures. This conscientious committee along with the pathologists of this state have persisted in their efforts to educate doctors to use qualified laboratories.

The members of the School Health Committee along with its many other efforts, completed and published a symposium on the Medical Aspects of Participation in High School Athletics. This has been hailed as an outstanding, practical guide not only for Ohio but also for other states.

Our Rural Health Committee continues to present a most practical, informative, orientation program for medical school seniors and juniors at Ohio State and Cincinnati. Students have also shown constant enthusiasm for the committee's preceptorship program.

As you know, this committee studies and examines all candidates for our rural medical scholarship program and has the difficult task of deciding who is eligible and deserving.

### Well Represented In AMA

Excellent accomplishments on the part of our delegates and alternates to the AMA have been numerous, climaxed by the election of Dr. Charles Hudson to the Board of Trustees and appointment of Dr. George Woodhouse to the chairmanship of the important Judicial Council.

There has been a closer coordination between the delegates and The Council so that our representatives to the AMA have complete understanding of our problems and our wishes.

Our delegation must continue their initiative and maintain constant liaison with other states. They must be ready not only to seek appointments but be ready to serve as our representatives on committees in the AMA.

The OSMA supported Senate Bill 550 which permits physicians and other professions to incorporate in order that they can enjoy pension and insurance benefits allowed employees of incorporations under the Internal Revenue Code. The Council approved the measure after making sure that its provisions would not be contrary to the Principles of Medical Ethics.

### AMPAC Endorsed

Your Council has endorsed AMPAC or the American Medical Political Action Committee. AMPAC was organized under the guidance of the AMA — but is now a separate organization with offices and quarters of its own.

Its purpose is to meet an utmet need — the need of providing the medical profession with an opportunity to assume a more active and effective role in political affairs.

AMPAC's dual role is (1) to help its members understand political issues and (2) to organize them as an effective political action group.

AMPAC is a permanent organization and certainly deserves not only the interest but support of all physicians, their families and friends because this is one more tool that doctors of medicine can use to prevent this country from becoming a welfare state.

### Fight Against HR 4222

Our actions and activities against the King-Anderson Bill should be known to everyone in Ohio.

A recital of what we have done is not necessary here except to tell you that the unprecedented activity and requests for advice, help and literature made it necessary to hire additional clerks in March to expedite all efforts.

Is it worth it?

What is the citizenship responsibility of a doctor?

I see it as an awakening from an apathetic age to see and to understand the basic duties of American individuals to protect and to save our competitive enterprise system.

I see it as an awakening of citizenship responsibility to participate on an informed basis.

It is worth it because participation in political and legislative affairs in the end will place responsible citizens in our local, state and federal legislatures.

It is worth it because it will help keep the government out of our personal lives.

It is worth it because it will help to give government back to the individual citizen and away from organized pressure groups.

It is worth it because we must have legislation based on reason, facts and need and not on emotion or political expediency.

Socialism divides what we have instead of creating something new and better. If we continue to reject

# Legislative and Policy-Making Body in Session



*This scene shows the House of Delegates in action during one of its two sessions. The House met on Monday evening and on Wednesday morning.*

the common-sense criteria of efficiency and soundness, we will get worse than poor service.

Raymond Moley once said, "Economic laws and common sense are not created by government. Nor can they be repealed by Congress." He added, "The liberals have a costly way to run a government. But it is going to be that way until a tax-burdened electorate is more careful about the people it chooses to run things."

The decision is up to you. It is getting pretty late to say, "I am too busy."

What can you do? If by now you still do not know — by all means don't write — call our Columbus office.

### No Dictation

I have used considerable time to review with you a few of the many programs and activities of your Ohio State Medical Association.

Yours is one of the largest and most active medical organizations in the country, working not only for the medical profession but for the people of Ohio and our nation.

Yours is one of the few remaining truly democratic organizations in existence in this country. Those who constantly insist that organized medicine is a powerful union that dictates to its membership and the public never were more wrong.

A review of the accomplishments of your organization this year — published for all to see — shows that in no instance has the OSMA dictated to a county society what it should or should not do.

On the contrary with the help of the county societies, committee representatives and a Council representing every region of this state, we have worked together to find the facts of many situations and then by agreement, or majority vote, have provided decisions and policy that an individual county society could accept or reject.

Nobody in this organization dictates a "must" action to anybody except in matters of ethics.

We have no highly paid medical executives. Rather, we have hundreds of dedicated doctors who have spent untold hours and energy, and at times, traveled great distances to be a part of what we call organized medicine.

The persistent criticisms of our organization by physicians, as well as the public, are kept alive because of misunderstanding, misinformation or a lack of knowledge. If the individual physician fails to exercise the responsibility, authority and power which he has, that is the fault of the individual, not the organization which was created by physicians and should be governed by the majority of its membership.

### Unity Is Imperative

It seemed to your president a year ago that one of our most pressing needs was to unite all doctors, all county organizations, all G. P. and specialty groups into one efficient, informed organization working together and supporting each other. It was evident quite quickly that a major problem has been that doctors had either forgotten or never did know of the great number of accomplishments of organized medicine, its liaison with more than 100 organizations and its services to the profession, to ancillary

professions and to the public — enough to fill a book.

Your president, president-elect and the office staff, used the slogan "Propaganda — Yours or Whose" during their visits into every district in the State last fall. The attendance and response to these efforts have been gratifying because as I have mentioned earlier there seems to be a greater spirit of cooperation and a new interest and undertsanding coming to the surface.

The great problems of social welfare that have been placed on our doorstep cannot be solved by individual efforts — an understanding, efficient, completely supported and unified organization is needed.



*Dr. and Mrs. Petznick admire the engraved silver tray presented to the Outgoing President as a token of appreciation for a job well done in behalf of the Association.*

We must continue to work together to defeat the growing welfare state or as individuals we will succumb to the "bit by bit" tactics of those who promote socialization.

You should be very proud of the accomplishments and of the greatness of your Ohio State Medical Association. But, this is not enough. The doctors of Ohio and through them, the people of this state, should start a ground-swell of ringing support in every direction, that will out-shout the shallowness of those trying by any devious manner to defame organized medicine.

I earnestly make a plea to all doctors to really know your organization, how it functions, its activities with allied health agencies, and then unite and support it.

Unity will create the strength to win and hold our objectives.

This same strength of unity cultivated here will develop a sound pattern for the future of medicine — a future with its possibilities, its hopes and its forebodings that will determine the health of the nation; a future that must answer the questions being raised now in regard to the government's multi-billion dollar research program and its effects on education and faculties; a future that has the promise of remarkable scientific achievements but in which the course of medicine and medical care will undergo great changes, the extent of which changes will be determined by the desires of the people and by the concerted, fully informed activities of those who belong to the medical profession.

### Must Have the Facts

The medical profession will never solve the increasing socio-economic problems facing it if it is only superficially intelligent as to the facts, the activities, the accomplishments and the methods of cooperation of its own organization.

In this challenge we must indeed recognize the need for the best possible thinking and the greatest possible unity if we are to maintain our position of trust, responsibility and leadership in the medical affairs of our state and of our country.

In conclusion I want to say that it has been a distinct privilege and honor to serve as president of this great, active, and energetic Ohio State Medical Association. The effort, the time and the anxieties have been small in comparison to the rewards and grand experiences gained through serving you. I will cherish forever the friendships made in Ohio and in other states among the members of our great and dedicated profession.

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## Aerospace Medicine Course Scheduled at OSU

The Department of Preventive Medicine at Ohio State University will hold its Ninth Annual Postgraduate Course in Aerospace Medicine Monday through Friday, September 10-14, in the Health Center. Attendance will be limited to 125 on a first-come, first-served basis.

The course is designed for physicians and scientists active in aviation and space medicine. Registrations are being accepted by Dr. John A. Prior, director of the College of Medicine's Center for Postgraduate Medical Education, 1645 Neil Ave., Columbus 10, Ohio. Tuition will be $75.

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The University of Cincinnati has announced that for the first time at any American university, and perhaps for the first time anywhere, the graduate school is offering doctoral study in the philosophical implications and moral presuppositions of psychiatry.

# Inaugural Address . . .

## Basic Criteria, as Set Forth in OSMA Constitution, Stressed by Incoming President in Accepting Gavel

*By* GEORGE J. HAMWI, M.D., Columbus

"THE purposes of this association are to promote the science and art of medicine and the protection of public health."

Thus reads the first sentence of Article 2 of the Constitution of the Ohio State Medical Association.

Since these are our avowed purposes, it should be stressed repeatedly that these are the basic criteria that we, as a group of physicians, should use in evaluating the righteousness of any action that we initiate or oppose.

### A Working Reality

The fact that the people of our country are now receiving as good or better medical care than any country in the world attests to the fact that this aim of our organization is not on ethereal principle, but a working reality. These comparisons of the quality of medical care include those countries which have had governmental control of medicine for many years and our nation suffers not one whit in the comparison. The social, economic, medical, and philosophic reasons for opposing the legislation proposed by our Federal government have been documented repeatedly and therefore require no repetition at this time.

Unfortunately, reason is no longer predominant. Quoting from the *New England Journal of Medicine:* "Political battles, like political campaigns, are won more often than not by the partisans who are better organized and better financed. Merit and logic are lost in harangue and principles sullied in propaganda."

### Aggressive Leadership Needed

Although the medical care in this country is as good or better than provided in any other nation, there is no doubt that it can be improved. Since health care is now considered within the province of a number of social groups, it behooves us to take active, aggressive leadership in planning for the health needs of our communities and the nation.

In spite of accusations to the contrary, the American Medical Association has provided extensive, if not always, aggressive leadership as has been described by our immediate past-president, George Petznick.

Because other social groups, such as labor unions, industry, state and federal governments, are bartering our services for political purposes, irrespective of quality, it behooves us to actively demonstrate that we are more capable than any other group of providing optimum medical care for all American people.

### Cohesive Action Possible

It is fortunate, indeed, that the existing structure of the Ohio State Medical Association and the American Medical Association provides the framework for cohesive action by all doctors, regardless of special interests. For quoting again from our constitution,



*Outgoing President George W. Petznick, left, relinquishes the rostrum to Incoming President George J. Hamwi, at the final session of the House of Delegates.*

Article 2, Sentence 2, "More especially, the purposes of this organization shall be to federate and bring into one compact organization the entire medical profession of the State of Ohio and to unite similar organizations in other states to constitute the AMA."

This unity of purpose and action of all segments of medicine is imperative if we are to provide the leadership necessary to preserve and maintain the concept of the physician as a capable, self-disciplined, ethical provider of the optimum health services to the people of the United States.

# House of Delegates Meetings 1962 Annual Meeting

## MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the 1962 Annual Meeting of the Ohio State Medical Association was held in the Grand Ballroom of the Neil House, Columbus, on Monday evening, May 14. There was a dinner with a business session following.

The Reverend Dr. Otis A. Maxfield, First Community Church, Columbus, offered the invocation.

Following the invocation, Dr. Richard L. Fulton, Columbus, President of the Columbus Academy of Medicine, welcomed the delegates to Columbus and introduced President George W. Petznick, Shaker Heights, who delivered his presidential address. (See page 796 for Dr. Petznick's address.)

### Delegates Present Numbered 155

The roll was called by the Executive Secretary who reported 155 delegates seated and eligible to vote. A considerable number of alternates and officers and executive secretaries of county medical societies also were in attendance.

### 1961 Minutes Approved

The minutes of the 1961 sessions of the House of Delegates, as published in *The Ohio State Medical Journal,* were approved by acclamation.

### Introduction of Guests

President Petznick introduced the following guests who were given an ovation by the House of Delegates: Dr. G. L. Simpson, Greenville, Kentucky, President of the Kentucky State Medical Association; Dr. W. Benson Harer, Upper Darby, Pennsylvania, President-Elect of the Pennsylvania Medical Society; Dr. D. E. Greeneltch, Wheeling, West Virginia, President of the West Virginia State Medical Association; Dr. James S. Klumpp, Huntington, West Virginia, former president of that state medical society; Mr. Ronald A. Naille, Columbus, President, and Mr. Joseph Gable, Columbus, President-Elect, Student AMA, Ohio State University College of Medicine; Dr. Earl G. Jones, Columbus, Secretary of the Ohio State Dental Society; Mr. R. Robert Wilson, Columbus, Executive Secretary of the Ohio Academy of General Practice; Mr. Edgar O. Mansfield, Columbus, President of the Ohio Hospital Association; Mr. Harold Emerson, Toledo, President, and Mr. John Kirwin, Columbus, Executive Secretary, Ohio State Pharmaceutical Association.

Introductions were made also of the following past-presidents and former members of The Council who occupied special tables:

**Past-Presidents**—A. A. Brindley, Maumee; H. M. Clodfelter, Columbus; Robert S. Martin, Zanesville; Frank H. Mayfield, Cincinnati; Richard L. Meiling, Columbus; H. M. Platter, Columbus; L. Howard Schriver, Cincinnati; and C. C. Sherburne, Columbus.

**Former Members of The Council** — R. Dean Dooley, Newark; Ross M. Knoble, Sandusky; William F. Mitchell, Columbus; H. T. Pease, Wadsworth; Arthur J. Tronstein, Newark; H. P. Worstell, Columbus.

The House of Delegates arose and gave a standing ovation to Dr. Platter, Columbus, the oldest living past-president and for many years secretary of the State Medical Board.

Dr. Petznick read a communication from Dr. George A. Woodhouse, Pleasant Hill, past-president, who was unable to attend the meeting because of illness, and the House of Delegates by acclamation adopted a motion expressing to him the hope for a complete and early recovery.

### Auxiliary President Speaks

Mrs. Lester W. Sontag, Yellow Springs, President of the Woman's Auxiliary, present by invitation, was escorted to the platform by Dr. Charles W. Hoyt, Cincinnati, Chairman of the Woman's Auxiliary Advisory Committee. Following her introduction she presented a report on the activities of the Auxiliary for the past year. (See page 827 for Mrs. Sontag's remarks.)

Mrs. Edward Bauman, Warren, President-Elect of the Woman's Auxiliary to the Ohio State Medical Association, and several other Auxiliary officials and members were in the audience. Dr. Petznick asked them to stand and they received the applause of the House of Delegates.

### History of Official OSMA Gavel

Dr. Petznick at this point referred to the official gavel which he was using. He told the House of

Delegates that it was made from the flagpole carried by the Lakeside Unit, Cleveland, in World War I, which flagpole carried the first American flag in Europe in World War I. The Lakeside Unit consisted of Base Hospital No. 4, U. S. Army. The gavel was presented to the Association in 1920 by the late Dr. George W. Crile, who was commander of the Lakeside Unit. Dr. Petznick pointed out that a series of articles on the activities of the Lakeside Unit in World War I is now being published in *The Ohio State Medical Journal* under the Historian's Notebook section.

### Reference Committees

The following reference committees were appointed by Dr. Petznick:

**Credentials of Delegates** — Kenneth D. Arn, Dayton, chairman; Edwin W. Burnes, Van Wert; Edward A. Webb, Ravenna; James A. L. Toland, Cambridge; Sol Maggied, West Jefferson; N. P. Stauffer, Millersburg.

**President's Address** — William E. Forsythe, Cleveland, chairman; Robert A. McLemore, Springfield; Frederick P. Osgood, Toledo; James G. Roberts, Akron; Mel A. Davis, Columbus; Albert B. Huff, Wooster.

**Resolutions Committee No. 1** — John H. Budd, Cleveland, chairman; Edmond K. Yantes, Wilmington; Maurice M. Kane, Greenville; Frederick T. Merchant, Marion; Thomas F. Tabler, Holgate; R. K. Ramsayer, Canton; R. E. Rinderknecht, Dover; Jack L. Kraker, Lancaster; Oscar W. Clarke, Gallipolis; J. M. Hedges, Circleville; Myrle D. Shilling, Ashland.

**Resolutions Committee No. 2** — William F. Bradley, Columbus, chairman; J. Martin Byers, Greenfield; Theodore L. Light, Dayton; Dwight L. Becker, Lima; Paul F. Orr, Perrysburg; Benjamin S. Park, Painesville; Walter A. Hoyt, Jr., Akron; Elias Freeman, Cadiz; J. R. Wells, Newark, J. R. Sheets, Portsmouth; James T. Stephens, Oberlin.

**Resolutions Committee No. 3** — Frank F. A. Rawling, Toledo, chairman; Robert E. Howard, Cincinnati; Isadore Miller, Urbana; Donald R. Brumley, Findlay; S. A. Burroughs, Ashtabula; G. E. DeCicco, Youngstown; F. W. Cook, Martins Ferry; Earl R. Haynes, Zanesville; George N. Spears, Ironton; James C. McLarnan, Mt. Vernon; Richard W. Avery, Seville.

### Nominating Committee Chosen

The next order of business was the election of a Nominating Committee. The House of Delegates nominated and elected the following Committee on Nominations:

**First District** — Daniel V. Jones, Cincinnati.

**Second District** — Chester J. Brian, Eaton.

**Third District** — Fred P. Berlin, Lima.

**Fourth District** — Edward F. Ockuly, Toledo.

**Fifth District** — Joseph L. Bilton, Cleveland.

**Sixth District** — Fred F. Somma, Cuyahoga Falls.

**Seventh District** — Robert R. Johnson, Coshocton.

**Eighth District** — Alton J. Ball, New Lexington.

**Ninth District** — Oscar W. Clarke, Gallipolis.

**Tenth District** — Robert E. Swank, Chillicothe.

**Eleventh District** — John W. Newman, Avon Lake.

Dr. Petznick appointed Dr. Jones of Hamilton County as temporary chairman of the committee for the purpose of calling the committee together for organization and business.

### Presentation of Resolutions

President Petznick then called for the presentation of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to delegates in advance of the meeting should be read by title only for referral. Twenty-one resolutions were read by title only and referred to the resolutions committees or to The Council. **(See minutes of the second session of the House of Delegates for text of each resolution and actions thereon.)**

### Resolutions Referred to Council

The following three resolutions were referred to The Council for consideration and action at a later date inasmuch as they referred to ethical matters: Use of the Term "Center" for Physicians' Offices (Clermont County); Wording of Statement on Free Choice (Hamilton County); and Medical Ethics (Summit County).

In taking this action Dr. Petznick referred to the following sections of the Constitution and Bylaws of the Ohio State Medical Association:

Chapter 4, Sec. 4.

"For the purpose of expediting proceedings the President shall appoint from the members of the House of Delegates the following reference committees, viz., Committee on President's Address; Committee on Resolutions, to which shall be referred all resolutions (except those of an ethical nature involving professional relations, which shall be referred to the Council without discussion, and those dealing with the time and place of the annual meeting, which shall be referred to the Committee on Time and Place of Meeting); Committee on Credentials; Committee on Time and Place of Annual Meeting; Committee on Tellers and Judges of Election; and other committees considered necessary by the President."

Chapter 8, Sec. 4, fifth paragraph:

"The Council shall be the board of censors of this Association, considering all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or a general meeting shall be referred to the Council without discussion. It shall hear and decide all

questions of discipline affecting the conduct of members or of a component society. Its decisions in all cases, including questions regarding the right of membership in this Association, shall be final."

Texts of the three resolutions referred to The Council are as follows:

### Use of the Term "Center" For Physicians' Offices

(By the Delegate from Clermont County)

WHEREAS, The assuming of a name for the offices of a Doctor of Medicine or a group of Doctors of Medicine has for its purpose, publicity, the intent of which is not always in the best interests of the public or of other Doctors of Medicine; and

WHEREAS, The use of a geographic location such as the name of a town or village usurps such name and falsely indicates to the laity a type of community enterprise, and implies also a town proprietorship on the part of the doctor or doctors involved; and

WHEREAS, The use of the word "CENTER" implies that other Doctors of Medicine who practice in the town or area are on the fringes, professionally; and

WHEREAS, The combination of the name of the town and the word "CENTER" is particularly revolting to the other Doctors of Medicine who practice in the same area; now therefore,

BE IT RESOLVED, That the Clermont County Medical Society considers it to be unethical for a Doctor of Medicine or a group of Doctors of Medicine to use the name of a geographic location or the word "CENTER" in connection with their office or offices; and further,

BE IT RESOLVED, That this resolution be presented to the house of Delegates of the Ohio State Medical Association at the annual meeting at Columbus, Ohio on 14 May 1962, for incorporation in the By-Laws of the Ohio State Medical Association.

### Wording of Statement on Free Choice

(By the Delegates from the Academy of Medicine of Cincinnati and Hamilton County)

WHEREAS, The American Medical Association does not qualify nor describe the meaning of the term "free choice of physician"; and

WHEREAS, The Ohio State Medical Association's statement on third party plans uses the term "reasonable degree of free choice," therefore,

BE IT RESOLVED, That the words "a reasonable degree of" be deleted from such statement so that it will read "when free choice of physician", etc., to conform with use of the term by the American Medical Association.

### Medical Ethics

(By the Delegates from Summit County)

WHEREAS, Section 4, Chapter 4 of the By-Laws of Ohio State Medical Association has been interpreted to mean that any resolution dealing with the subject of professional relations with osteopaths is per se of ethical nature and thus must be referred to the Council of Ohio State Medical Association without discussion by this House of Delegates, and

WHEREAS, This House of Delegates feels the intent of this provision did not include taking from the purview of this House control of basic policy on the question of professional association with osteopaths, therefore

BE IT RESOLVED, That this question of interpretation be referred to a committee of this House for an opinion which this House may then ratify or reject.

## Three House Reference Committees in Action







*Important in the function of the House of Delegates are its Reference Committees which hear testimony on various Resolutions and bring back recommendations to the House. Here the three committees are seen in action.*

### One New Resolution

Dr. Petznick then asked if there were any new resolutions. Gaining recognition, Dr. John J. McDonough, delegate from Mahoning County, asked permission of the House under the two-thirds rule to present a resolution entitled "Traditional Policy of Ohio State Medical Association" reading as follows:

WHEREAS, The House of Delegates of the American Medical Association introduced this resolution in June, 1961, and

WHEREAS, The wording of this magna carta resolution

remains the traditional policy of the Ohio State Medical Association, therefore,

BE IT RESOLVED. That the Ohio State Medical Association endorse and reaffirm unanimously the following text:

"The House of Delegates of the American Medical Association records its opposition to any legislation of the King-Anderson type. Its opposition is based on the facts that such legislation does not meet the needs of the situation, interferes with the doctor-patient relationship, interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachments by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest.

"The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

"The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest and that it will not be a willing party to implementing any system which we believe to be detrimental to the public welfare."

**By a voice vote the House of Delegates gave Dr. McDonough permission to introduce the resolution which he did. The resolution was referred to Resolutions Committee No. 2.**

Following announcements about meetings of the reference committees and the second session of the House of Delegates the House then recessed until Wednesday morning, May 16.

## MINUTES OF SECOND SESSION

The second session of the House of Delegates of the Ohio State Medical Association at the 1962 Annual Meeting was held on Wednesday morning, May 16, in the Grand Ballroom of the Neil House.

A roll call by the Executive Secretary showed 157 delegates seated and eligible to vote.

### Guests Introduced

Guests who were not present at the first session of the House of Delegates were then introduced by the President. They included Dr. Maurice E. Glock, Fort Wayne, Indiana, President-Elect of the Indiana State Medical Association and Dr. Donald H. Stubbs, Washington, D.C., former President of the District of Columbia Medical Society and former President of the National Blue Shield Plans. Each addressed the House of Delegates and received an ovation.

### Committee on President's Address

The next order of business was the report of the Reference Committee on President's Address, presented by Dr. William E. Forsythe, Cleveland, which read as follows:

"The committee applauds President Petznick's address. He again shows the high leadership which we have come to expect in the Ohio State Medical Association. With full knowledge that the job is too great for one man, tribute was paid to the Past-President, President-Elect, executive staff, Council and other officers. Dr. Petznick emphasized the changing problems of the medical profession and listed some of the significant changes during the past year. With realization of increased political activities on the part of physicians, he strongly endorsed the need for and action of the American Medical Political Action Committee.

"Dr. Petznick stressed physician responsibility. He emphasized the need for the profession to awaken from apathy and the increased responsibility to participate in public affairs. With the knowledge that socialism does not lead to better service, he stressed the wish of all to keep government out of private lives.

"The committee again wishes to congratulate Dr. Petznick on a job well done."

**By official action, the report of the committee was approved.**

### Report of Resolutions Committee No. 1

Dr. John H. Budd, Cuyahoga County, then reported for Resolutions Committee No. 1, of which he was chairman. The report read as follows:

"The committee had originally referred to it eight resolutions which were submitted to the House at its first session. Because of time devoted to some of the resolutions hearings, two resolutions, namely, 'Traditional Policy of Ohio State Medical Association' and 'Political Action by the Medical Profession', were transferred to Resolutions Committees No. 2 and No. 3 respectively.

"Many members of the House of Delegates as well as other members of the Association appeared before the committee to discuss these resolutions. Discussion was thorough, enlightening, vigorous and dignified.

"After the open hearing the committee carefully studied each resolution and the arguments presented at the open hearing."

### Proposed Increase in Annual Dues

"This resolution was introduced by Dr. P. B. Hardymon, Columbus, Treasurer of the Association, on behalf of The Council and it read as follows:

BE IT RESOLVED, That the per capita annual dues of the Ohio State Medical Association shall be increased from $30.00 to $35.00, effective January 1, 1963.

"It was the considered opinion of the committee that the evidence presented in behalf of The Council adequately justified the proposal. There was no opposition whatever expressed and the committee recommends that the resolution be adopted. Mr. President, I so move."

**By official action, the recommendation of the committee, that the resolution on increase in dues be adopted, was approved.**

### Tax Deduction of Health Insurance Premiums

"This resolution was introduced by the delegate from Huron County and read as follows:

WHEREAS, The basic concepts of free Americanism are at stake, and

*(Continued on Next Page)*

WHEREAS, The free practice of medicine is in extreme jeopardy, and

WHEREAS, The Ohio State Legislature has failed to implement the Kerr-Mills bill for Ohio, and

WHEREAS, Most physicians feel that H. R. 4222 offers no good solution for the medical care of the medically indigent either over or under 65 years of age, and

WHEREAS, The American Medical Association has failed to offer a good positive solution for the problem of the medical care of the medically indigent, thereby giving the defenders of free medicine only a negative approach, and

WHEREAS, The federal government has brought about this problem primarily by its high taxation and encouragement of the population to rely upon the federal government for all things, therefore

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association go on record as supporting a program which would give tax relief and permit deductions of premiums of voluntary medical insurance for all ages. Furthermore, be it resolved that those aged people not having suitable income to enable them to pay their voluntary medical insurance premiums have certificates offered to be accepted by insurance companies as payment of such premiums, and further,

BE IT RESOLVED, That the Ohio State Medical Association House of Delegates instruct the delegates of the American Medical Association of this approach and advise them to work for its acceptance and promotion by the American Medical Association.

"From the evidence adduced and the majority of opinions expressed, the committee believes that the care of the aged has become a political issue for both parties, that compromise positions are being suggested from various areas and that substitute or additional legislation, regardless of some of the desirable features included, tends to weaken our position and should not be introduced at this time. Therefore, the committee recommends that this resolution be disapproved. Mr. President, I move that the recommendation of the committee be accepted, namely, that the resolution be not adopted."

**By official action, the House of Delegates approved the recommendation of the committee that this resolution NOT be adopted.**

### Inclusion of Laboratory Services Under Blue Shield Contracts

"This resolution was introduced by the delegates from Cuyahoga County and it read as follows:

WHEREAS, The House of Delegates of the American Medical Association has repeatedly stated that the practice of pathology is the practice of medicine, and

WHEREAS, The guides for physicians in relationship with hospitals state: "If hospital service is limited to include only hospital room accommodations such as bed, board, operating room fees, medicines, surgical dressings and general nursing care, the distinction between hospital and medical services will be clear," and

WHEREAS, The Council on Medical Services of the American Medical Association and its Committee on Insurance and Prepaid Plans have expressed concern over the lack of transfers of such professional services into professional care plans (Blue Shield), now therefore,

BE IT RESOLVED, That the Ohio Medical Indemnity, Inc. (Blue Shield) be urged by the Ohio State Medical Association to develop plans and mechanisms to assimilate these professional services, and further,

BE IT RESOLVED, That the Ohio Medical Indemnity, Inc. restore the laboratory services recently deleted from its contracts and to expand further out-patient laboratory coverage.



*Dr. Daniel V. Jones, Cincinnati, Chairman of the Nominating Committee, reports to the House.*



*Dr. Wm. D. Forsythe, Cleveland, Chairman of the Committee on the President's Address, reports.*

"In the committee's deliberations due consideration was given to the eloquently expressed views presented. "The committee is in sympathy with the expressed desire of the pathologists to maintain their identity as physicians and to support the principle of reimbursement for medical professional services by medical professional insurance. The committee is also impressed by the declared willingness of Blue Shield representatives to discuss ways and means of covering physicians' services where feasible. A sublimation of the viewpoints expressed is sought in the form of the following substitute resolution:"

### Sub. Resolution on Inclusion of Laboratory Services Under Blue Shield Contracts

WHEREAS, The House of Delegates of the American Medical Association has repeatedly stated that the practice of pathology is the practice of medicine, and

WHEREAS, Certain laboratory services have recently been deleted from Ohio Medical Indemnity, Inc., contracts, therefore,

BE IT RESOLVED, That Ohio Medical Indemnity, Inc.,

be urged to develop plans for mechanisms to cover laboratory services when billed for by a physician.

"Mr. President, the committee recommends the adoption of the substitute resolution, and I so move."

Dr. E. H. Crawfis, delegate from Cuyahoga County, gained recognition of the chair and offered the following amendment to the substitute resolution: In the final resolve paragraph strike out the words "by a physician" and substitute the words "services by or under the supervision of a physician." This amendment was approved by the House of Delegates, making the amended substitute resolution read as follows:

### Amended Substitute Resolution on Inclusion of Laboratory Services Under Blue Shield Contracts

WHEREAS, The House of Delegates of the American Medical Association has repeatedly stated that the practice of pathology is the practice of medicine, and

WHEREAS, Certain laboratory services have recently been deleted from Ohio Medical Indemnity, Inc., contracts, therefore,

BE IT RESOLVED, That Ohio Medical Indemnity, Inc., be urged to develop plans for mechanisms to cover laboratory services when billed for services by or under the supervision of a physician.

**By official action the House of Delegates approved the recommendation of the committee that the substitute resolution, as amended, be adopted.**

### Revision of the Council on Medical Education and Hospitals

"This resolution was introduced by the delegates from Cuyahoga County and read as follows:

WHEREAS, Undergraduate Medical Education is a logical function of Medical Schools, and Graduate Training in Medical Specialties is a logical function of Hospitals, and

WHEREAS, These functions, although of two different levels of medical education, are now governed by one American Medical Association Council which "establishes and enforces standards"—The Council on Medical Education and Hospitals, and

WHEREAS, That Council as a result carries a tremendous load covering almost the entire spectrum of medical education and hospitals (22 sub-committees), now therefore,

BE IT RESOLVED, That the Ohio State Medical Association sponsor through its delegation to the American Medical Association House of Delegates the creation of two councils to replace the present Council on Medical Education and Hospitals—these to be known as (1) The Council on Undergraduate Medical Education and (2) The Council on Graduate Medical Education—each to have functions logically falling within the areas described in the title, and further,

BE IT RESOLVED, That each of the Councils should consist of ten members plus staff. The membership of the Council on Undergraduate Medical Education should consist of no more than eight members of medical school faculties and the membership of the Council on Graduate Medical Education should consist of no more than four members of medical school faculties.

"It was evident that the objectives of the resolution were warmly endorsed by those who attended the hearing. No opposing testimony was presented and the committee is in full agreement with the resolution and recommends its adoption as presented. Mr. President, I so move."

**By official action, the House of Delegates approved the recommendation of the committee that this resolution be adopted as presented.**

### Ohio Medical Indemnity

"This resolution was introduced by the delegates from Hamilton County and read as follows:

WHEREAS, Blue Shield has been identified as the "Doctors' Plan," and

WHEREAS, Blue Shield Plans offered through the facilities of the Ohio Medical Indemnity, Inc. are intended and planned for the benefit of patients, and

WHEREAS, Ohio Medical Indemnity, Inc. has been unable to retain contracts under certain competitive conditions, therefore

BE IT RESOLVED, That officials of Ohio Medical Indemnity, Inc. be authorized to offer patients such plans that are competitive with other insurance or health payment plans.

### Service-Type Insurance Plans

"This resolution was introduced by the delegates from Summit County and read as follows:

WHEREAS, The House of Delegates, Ohio State Medical Association, realizes that installing service-type insurance plans fundamentally changes the *economic* environment of practicing physicians in the short run, and

WHEREAS, Service-type insurance plans in some localities, by controlling a large *percentage* of a physician-member's income, usually come also to interfere with the *professional* environment of the physician and, in the long run, with how he practices medicine, and

WHEREAS, This House recognizes that relative-value fee schedules and "review committees" for full-payment programs that are based on full payment of "reasonable and ordinary charges" as well as plans setting forth specific fee schedules are *all* means to these same ends, therefore

BE IT RESOLVED, That this House of Delegates request Ohio Medical Indemnity to develop a *co-insurance* (85%-15%) contract to be offered as an alternative to its indemnity type policy, and further

BE IT RESOLVED, That this House reiterate its opposition to Ohio Medical Indemnity writing a service-type contract in fact or in effect — specifically, to writing a contract which *guarantees* full payment of physicians' fees.

"The final two resolutions identified as 'Ohio Medical Indemnity' (Hamilton County) and 'Service-Type Insurance Plans' (Summit County) were considered at length.

"Although it is evident that two divergent medical economic philosophies were expressed, they were considered together because they bear on the same fundamental question.

"Discussion was enthusiastic. Merit and logic were abundant on both sides and harangues were minimal. Testimony was presented for two hours and forty minutes.

"Deliberation in the Reference Committee executive session was likewise earnest, searching and prolonged.

"In the sincere hope of an acceptable solution the committee has produced the following substitute resolution. This resolution represents a majority opinion of the committee and not a unanimous opinion. The resolution reads as follows:

### Substitute Resolution on Ohio Medical Indemnity and Payment-in-Full Plans

WHEREAS, Blue Shield plans offered through the facil-

# Past-Presidents Honored



*Past-Presidents were honored at a dinner given by The Council the week of the Annual Meeting. OSMA Past-Presidents shown here are, left to right, Dr. M. D. Prugh, Dayton; Dr. Robert S. Martin, Zanesville; Dr. Harve M. Clodfelter, Columbus; Dr. L. Howard Schriver, Cincinnati; Dr. Carl A. Lincke, Carrollton; and Dr. Charles L. Hudson, Cleveland.*

ities of Ohio Medical Indemnity, Inc., are intended and planned for the benefit of patients, and

WHEREAS, Ohio Medical Indemnity, Inc., has been unable to retain contracts under certain competitive conditions, therefore,

BE IT RESOLVED, That Ohio Medical Indemnity, Inc., be authorized to offer an expanded indemnity plan which may be presented as a payment-in-full contract to groups who qualify by certain income limitations and when the service is rendered by a voluntarily participating physician.

For subscribers whose income exceeds the agreed limit the benefit will be an indemnity only.

When the physician is a non-participant the scheduled indemnity is still paid and the physician is free to bill the patient for the balance of his fee.

"Mr. President, the committee recommends the adoption of the substitute resolution, and I so move."

The motion was duly seconded and the question opened for debate.

Dr. William A. White, Stark County, moved that the motion to adopt the substitute resolution be laid on the table. This was seconded by Dr. Clarence V. Smith of Stark County.

Dr. Petznick called for a ballot on the motion to table the committee's recommendation and the resolution. Ballots were distributed and the delegates voted.

Dr. White, chairman of the Committee on Tellers and Judges of Election, reported that the motion to table received 31 votes and that there were 115 votes in opposition to the motion to table.

Following a vigorous debate on the pros and cons of the substitute resolution, **the House of Delegates cast a voice vote approving the motion for adoption of the substitute resolution and the substitute resolution was declared adopted.**

(A communication from Dr. Charles E. Casto, Akron, Secretary of the Summit County Medical Society, under date of May 25, 1962, to the Executive Secretary requested that the minutes show that the delegates from Summit County voted "no" on the recommendation of Resolutions Committee No. 1 that the substitute resolution should be adopted.)

Dr. Budd then moved that the report of Resolutions Committee No. 1 as a whole, as amended, be adopted. **The House of Delegates approved the motion by official action.**

### Statement By Chairman

Before leaving the rostrum Dr. Budd made this statement:

"It has been a satisfying experience to participate in the work of this committee. To all who appeared at the hearings I express the committee's thanks for the information presented, the opinions delivered and the courtesy of every speaker. I am personally grateful to other committee members for their constructive efforts, sincerity and above all, for their patience. They are: Edmond K. Yantes, Clinton County; Maurice M. Kane, Darke County; Frederick T. Merchant, Marion County; Thomas F. Tabler, Henry County; R. K. Ramsayer, Stark County; R. E. Rinderknecht, Tuscarawas County; Jack L. Kraker, Fairfield County; Oscar W. Clarke, Gallia County; J. M. Hedges, Pickaway County; and Myrle D. Shilling, Ashland County."

### Report of Resolutions Committee No. 2

A report of Resolutions Committee No. 2 was presented by Dr. William F. Bradley, Franklin County,

chairman of the committee. He pointed out that the committee had considered six resolutions and that much valuable testimony was presented; that the discussion was thorough, detailed, and at times protracted. The committee report follows:

### AAPS Essay Contest

"This resolution was presented by Dr. Charles W. Pavey, delegate from Franklin County, and read as follows:

BE IT RESOLVED, That the Ohio State Medical Association again renew its endorsement of the Essay Contest of The Association of American Physicians and Surgeons with the titles 1) The Advantages of The American System of Free Enterprise or 2) The Advantages of Private Medical Care.

"It is the opinion of the Resolutions Committee that the resolution should be adopted as published in *The Journal* of the Ohio State Medical Association under the title, 'Resolutions To Be Considered at 1962 Annual Meeting.'

"Mr. President, the committee recommends the adoption of the resolution, and I so move."

**By official action, the House of Delegates approved the recommendation of the committee that this resolution be adopted.**

### Driver's Training Courses and Physical Examinations for Automobile Drivers

"This resolution was introduced by the delegates from Cuyahoga County and read as follows:

WHEREAS, Traffic accidents have become the most important health problem of the nation, with 40,000 deaths and 1,350,000 injured annually, and

WHEREAS, Accidents occur through combinations of circumstances involving three variables: The driver, the vehicle, and the environment, and

WHEREAS, It has been shown that accident rates for trained drivers are half those of drivers without formal training (McFarland, R. A., and Moore, R. C., *New England Journal of Medicine,* 1957), and that numerous accidents occur because of serious physical disabilities which are more prone to occur with advancing years, and

WHEREAS, Driving an automobile is not an inalienable right, but rather a privilege based on fitness, ability, and other criteria; now therefore,

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association recommends:

1. That the completion of a driver's training course be required for licensure of all new drivers, and

2. That physical examinations initially and at specific intervals be required in the issuance and reissuance of drivers licenses. The standard medical evaluation form as recommended by the Traffic Safety Committee of the Ohio State Medical Association should be completed by the applicant's personal physician for this purpose. Regional medical review boards should be established to hear and rule on appeals in cases involving physical or mental disability.

"The majority of the testimony presented indicated that this resolution had the support of those who appeared. It is the opinion of the Resolutions Committee that paragraph number 2 in the BE IT RESOLVED should be amended to read as follows:

"2. The House of Delegates reiterates the recommendations of this Association's Traffic Safety Committee, said recommendations calling for initial and periodic physical and mental examinations for drivers by their personal physicians, and for regional medical review boards to hear and make recommendations on appeals in cases involving physical or mental disability, and the House urges the Ohio Director of Highway Safety to implement these recommendations."

"Mr. President, the committee recommends the adoption of the amended resolution, and I so move."

The amended resolution read as follows:

### Amended Resolution on Driver's Training Courses and Physical Examinations for Automobiles Drivers

WHEREAS, Traffic accidents have become the most important health problem of the nation, with 40,000 deaths and 1,350,000 injured annually, and

WHEREAS, Accidents occur through combinations of circumstances involving three variables: The driver, the vehicle, and the environment, and

WHEREAS, It has been shown that accident rates for trained drivers are half those of drivers without formal training (McFarland, R. A., and Moore, R. C., *New England Journal of Medicine,* 1957), and that numerous accidents occur because of serious physical disabilities which are more prone to occur with advancing years, and

WHEREAS, Driving an automobile is not an inalienable right, but rather a privilege based on fitness, ability, and other criteria; now therefore,

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association recommends:

1. That the completion of a driver's training course be required for licensure of all new drivers, and

2. The House of Delegates reiterates the recommendations of this Association's Traffic Safety Committee, said recommendations calling for initial and periodic physical and mental examinations for drivers by their personal physicians, and for regional medical review boards to hear and make recommendations on appeals in cases involving physical or mental disability, and the House urges the Ohio Director of Highway Safety to implement these recommendations.

**By official action, the recommendation of the committee, namely, that the amended resolution be adopted, was approved.**

### Mandatory Regulation That a Doctor of Medicine Be Present at All Ohio High School Athletic Body-Contact Contests

"This resolution was introduced by the delegates from Hamilton County and read as follows:

WHEREAS, The Ohio State Medical Association and its component medical societies and their committees have successfully sponsored athletic injury and advisory conferences for the benefit of the high school athlete, his team physician where such exists, his coach, trainer, school officials, and, indirectly, his family; and

WHEREAS, The success of these conferences and the good accrued from them is most excellent, it is evident that more can be done for the high school athlete if the present practice of some of the high schools to have an official team physician present at all athletic body-contact contests, be extended to include all official body-contact contests in all public and private high schools in the State of Ohio; and

WHEREAS, No uniform code delineating the authority and relationship between any physician acting as a team physician and the high school officials and coaches exists in the State of Ohio as a whole, therefore,

BE IT RESOLVED, That the Ohio State Medical Association House of Delegates instruct the Council of the

Ohio State Medical Association and it, in turn, instruct its proper committees to

(a) Continue the aforementioned athletic injury conferences at reasonable intervals and at geographic locations where the greatest number of high school athletes can receive the greatest amount of benefit; and

(b) Instruct the chairman of these committees to implement via the Athletic Control Boards of the Ohio State High School Athletic Association, the Ohio State High School Athletic Coaches Association, and all other proper organizations and authorities, a program which will result in agreement between these proper authorities and all high school officials in the State of Ohio that no official body-contact athletic contest will be played without a doctor of medicine present on the field from the beginning to the end of such contest; further

BE IT RESOLVED, That these committees of the Ohio State Medical Association write and implement a code of relationship between the doctor of medicine who will be the team doctor and the school officials which will establish, without doubt, the authority and the position of the team physician in all matters medical and surgical pertaining to any high school athlete before, during, and after such contests.

"After hearing much expert testimony by members of the Association who are vitally interested and closely associated with the problems mentioned in this resolution, the committee proposes a substitute resolution as follows:"

### Substitute Resolution Regarding Mandatory Regulation That a Doctor of Medicine Be Present at All Ohio High School Athletic Body-Contact Contests

WHEREAS, The Ohio State Medical Association and the Ohio High School Athletic Association have worked together effectively on an organized basis since the formation of their Joint Advisory Committee on Athletic Injuries in 1959; and

WHEREAS, This cooperation has resulted in the completion of two studies regarding athletic injury prevention practices in Ohio, the first of which has been published in *The Ohio State Medical Journal* and in *The Ohio High School Athlete,* official journal of the Ohio High School Athletic Association; and

WHEREAS, The Joint Advisory Committee, with the assistance of The Ohio State University College of Medicine has conducted a postgraduate medical course on athletic injuries for Ohio team physicians, and plans another such course on August 29 and 30, 1962; and

WHEREAS, The Joint Advisory Committee of the Ohio State Medical Association and the Ohio High School Athletic Association and component medical societies have sponsored both regional and county athletic injury conferences throughout Ohio for the benefit of the high school athlete, his team, his physician, his coach, his trainer, his school officials, and indirectly, the athlete's family and community, now therefore

BE IT RESOLVED, That the Ohio State Medical Association House of Delegates commends the Ohio High School Athletic Association for its enthusiasm and leadership in athletic injury prevention activities; and

BE IT FURTHER RESOLVED, That the House of Delegates congratulates those county medical societies which have held athletic injury conferences for the school people and physicians in their areas and encourages other societies to do likewise; and

BE IT FURTHER RESOLVED, That the House of Delegates instructs The Council of the Ohio State Medical Association to direct the appropriate committee to:

(a) Continue the excellent working relationship with the Ohio High School Athletic Association through the Joint Advisory Committee on Athletic Injuries; and

(b) Carry forward the aforementioned regional athletic injury conferences at reasonable intervals and at appropriate geographic locations.

(c) Step up the educational campaign to encourage county medical societies to develop in cooperation with county, exempted village, city, parochial, and private high schools in their counties a system whereby a physician will be assigned to each football game when a team physician is not present; and

(d) Encourage schools to make arrangements to obtain the services of a physician to counsel coaches and trainers on a continuous basis with regard to the medical aspects of the athletic program and to be available when emergencies arise in any sport.

(e) Encourage team physicians to avail themselves of the postgraduate medical courses on athletic injuries.

(f) Continue to utilize reports and information developed by the Committee on Medical Aspects of Sports of the American Medical Association in bringing to physicians, coaches, administrators, trainers, and the athletes themselves, current and authentic information with regard to developments in protective equipment and injury prevention and treatment in the broad sports program.

"Mr. President, the committee recommends the adoption of the substitute resolution, and I so move."

**By official action, the recommendation of the committee, namely, that the substitute resolution be adopted, was approved.**

### Uniform Physical Examination Form

"This resolution was presented by the delegates from Mahoning County and read as follows:

WHEREAS, For the past several years colleges and universities, both private and public, require applicants for admission to submit the results of physical examinations and history of past illnesses, injuries, operations and immunizations before admission to the college or university and even in some cases before considering the application for admission to the college or university, and,

WHEREAS, Each college and university has its own particular form to be completed, and

WHEREAS, Some applicants apply to several schools and bring to the examining physician two, three and even sometimes four separate blanks for completion, no two of which are alike, thus causing confusion in filling out the various forms and,

WHEREAS, If the several colleges and universities could agree on an entrance physical examination form similar to the scholastic college entrance board examinations it would greatly facilitate the procedure, both for the examining physician and the student applicants, therefore

BE IT RESOLVED, That the Mahoning County Medical Society go on record as urging the Ohio State Medical Association and the American Medical Association to facilitate and expedite the adoption of a uniform history and physical examination form by the several colleges and universities presently subscribing to the board of college entrance examiners and all other colleges and universities that can be contacted.

"The committee offers a substitute BE IT RESOLVED paragraph to read as follows:

"BE IT RESOLVED, That the Ohio State Medical Association, through the facilities of the American Medical Association, urge the American College Health Association to actively promote the adoption of a new uniform history and physical examination form by colleges and universities in the United States."

"This would make the amended resolution read as follows:"

### Amended Resolution on Uniform Physical Examination Form

WHEREAS, For the past several years colleges and universities, both private and public, require applicants for admission to submit the results of physical examinations and

history of past illnesses, injuries, operations and immunizations before admission to the college or university and even in some cases before considering the application for admission to the college or university, and,

WHEREAS, Each college and university has its own particular form to be completed, and

WHEREAS, Some applicants apply to several schools and bring to the examining physician two, three and even sometimes four separate blanks for completion, no two of which are alike, thus causing confusion in filling out the various forms and,

WHEREAS, If the several colleges and universities could agree on an entrance physical examination form similar to the scholastic college entrance board examinations it would greatly facilitate the procedure, both for the examining physician and the student applicants, therefore

BE IT RESOLVED, That the Ohio State Medical Association, through the facilities of the American Medical Association, urge the American College Health Association to actively promote the adoption of a new uniform history and physical examination form by colleges and universities in the United States.

"Mr. President, the committee recommends the adoption of the amended resolution, and I so move."

**The motion that the amended resolution be adopted was approved by official action.**

### Aid for The Aged

"This resolution was introduced by the delegates from Montgomery County and read as follows:

WHEREAS, It is becoming increasingly difficult to provide adequate and high quality medical services to patients under the Aid for the Aged program in Ohio; and

WHEREAS, A major cause of this difficulty is the unrealistic and low fee schedule established by Aid for the Aged; therefore

BE IT RESOLVED:

(1) That the Ohio State Medical Association take whatever steps that may be necessary to effect an upward revision of the Aid for the Aged fee schedule to a realistic level reflecting more closely today's cost of providing high quality medical service, and

(2) That, if necessary, efforts to secure this revision include full implementation of the Kerr-Mills law in Ohio.

"The testimony offered to the committee on the resolution entitled 'Aid for the Aged' was valuable and extensive. The committee in its deliberations felt that the resolution embodies many of the significant problems encountered in the Aid for the Aged program in Ohio. There is considerable activity on the part of the Committee on Care of the Aged of the Ohio State Medical Association, as well as in the Medical Advisory Committee of the Division of Aid for the Aged. Attempts are being made to consider the many facets of the problem of aid for the aged, jointly with members of the medical profession who must ultimately render the care, and the Division of Aid for the Aged, who must administer it in the light of the wishes of the Legislature of the State of Ohio.

"The committee feels that the first BE IT RESOLVED of the resolution is now being worked on very vigorously to the end that this resolve is unnecessary.

"The second BE IT RESOLVED ultimately must consider the matter from a financial point of view and, as such, a Kerr-Mills Law in Ohio would likely cost the state considerable money. For example, under the Mills Law, now in operation in Ohio, the State of Ohio receives 58¢ from the Federal Government for each dollar expended (the state contributing 42¢). Under the Kerr-Mills Law, the State of Ohio would receive only 50¢ for each dollar expended.

"Therefore, no action was taken on this resolution.

"Mr. President, the committee recommends that no action be taken on this resolution, and I so move."

**By official action, the recommendation of the committee, namely, that no action be taken on this resolution, was approved.**

### Traditional Policy of Ohio State Medical Association

This resolution was introduced at the first session of the House of Delegates by consent of two-thirds of the delegates present, since it had not been previously published. It read as follows:

WHEREAS, The House of Delegates of the American Medical Association introduced this resolution in June, 1961, and

WHEREAS, The wording of this magna carta resolution remains the traditional policy of the Ohio State Medical Association, therefore,

BE IT RESOLVED, That the Ohio State Medical Association endorse and reaffirm unanimously the following text:

"The House of Delegates of the American Medical Association records its opposition to any legislation of the King-Anderson type. Its opposition is based on the facts that such legislation does not meet the needs of the situation; interferes with the doctor-patient relationship; interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachments by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest.

"The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

"The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest and that it will not be a willing party to implementing any system which we believe to be detrimental to the public welfare."

"The committee is in agreement with the sentiments expressed in this resolution and believes they reflect the position of the Ohio State Medical Association.

"Minor amendments in the WHEREAS paragraphs of the resolution are suggested, making the amended resolution read as follows:

### Amended Resolution on Traditional Policy of Ohio State Medical Association

WHEREAS, The House of Delegates of the American Medical Association adopted a resolution in June, 1961, pertaining to King-Anderson type legislation, and

WHEREAS, The wording of this magna carta resolution embodies the traditional policy of the Ohio State Medical Association, therefore,

BE IT RESOLVED, That the Ohio State Medical Association endorse and reaffirm unanimously the following text:

"The House of Delegates of the American Medical Asso-

ciation records its opposition to any legislation of the King-Anderson type. Its opposition is based on the facts that such legislation does not meet the needs of the situation; interferes with the doctor-patient relationship; interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachments by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest.

"The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

"The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest and that it will not be a willing party to implementing any system which we believe to be detrimental to the public welfare."

"Mr. President, the committee recommends the adoption of the amended resolution, and I so move."

**By official action, the recommendation of the committee, namely, that the amended resolution be adopted, was approved.**

**Dr. Bradley then moved that the report of Resolutions Committee No. 2 as a whole, as amended, be adopted.**

**By official vote the motion was approved by the House of Delegates.**

### Committee Thanked

The following statement was presented by Dr. Bradley with respect to the work of his committee:

"The committee is grateful for the presence and testimony of the many members of the Association and invited guests. The committee feels that each had an opportunity to be heard, and the committee greatly appreciated the opportunity of hearing the views of each member.

"The Chairman wishes to thank each member of the committee for their time, effort, guidance and wisdom." Members of the committee participating were: J. Martin Byers, Highland County; Theodore L. Light, Montgomery County; Dwight L. Becker, Allen County; Paul F. Orr, Wood County; Benjamin S. Park, Lake County; Walter A. Hoyt, Jr., Summit County; Elias Freeman, Harrison County; J. R. Wells, Licking County; J. R. Sheets, Scioto County; James T. Stephens, Lorain County.

### Report of Resolutions Committee No. 3

Dr. Frank F. A. Rawling, Lucas County, presented the report of Resolutions Committee No. 3, of which he was chairman, pointing out that the committee was aided by spirited and informative discussion by members who appeared before it. The report read as follows:

### Request to American Medical Association On Public Relations Items

"This resolution was introduced by the delegates from Hamilton County and read as follows:

WHEREAS, Medical matters in the lay press are frequently releases from national news wires; and

WHEREAS, These releases are frequently with emotional appeal which are detrimental to the entire medical profession; and

WHEREAS, These news releases have not been cleared by the local medical society and the circumstances investigated to determine the validity of the news material; and

WHEREAS, The American Medical Association has in the past referred the investigation of these matters to the local medical society AFTER the news releases have appeared in the lay press; and

WHEREAS, The local medical society has no facilities to clear these matters released by national wire services before the release; and

WHEREAS, The American Medical Association has the National Communications and News Facilities to discuss medical news releases on a high level with high level officials of the national news services; and

WHEREAS, Collaboration on the truth and validity of the news releases and their impact on the lay public can



*The House of Delegates referred resolutions to three Resolutions Committees which heard testimony and reported back to the House. Here are the three chairmen shown making their reports to the House. Left to right are Dr. William F. Bradley, Columbus; Dr. John H. Budd, Cleveland; and Dr. Frank F. A. Rawling, Toledo.*

only be assessed after investigation of the subject matter involved, therefore,

BE IT RESOLVED, That the appropriate agency or agencies of the American Medical Association request the national wire services not to publish such material until the American Medical Association has had this material investigated by the local medical society to determine the circumstances or the truth of the proposed release, and then if the matter is reported in its true light, the medical profession has no complaint with the subject matter regardless of what its results might be.

"It is the unanimous recommendation of our committee that this resolution not be adopted. It presents an approach to the control of news releases that would be impractical and not be in the best interests of our profession nor the press in the dissemination of information. Good relationship of local medical societies with the press is considered the best method and is the responsibility of each county medical society. The committee submits the following substitute resolution to draw attention to this important area:

### Substitute Resolution on Request to American Medical Association on Public Relations Items

WHEREAS, A close working relationship between the local medical society and news media is necessary to provide the public with adequate and accurate medical news, and

WHEREAS, The 1959 District Public Relations Conferences initiated by the then OSMA President, Frank H. Mayfield, M.D., Cincinnati, were enthusiastically received by representatives of the news media, and

WHEREAS, These media representatives strongly indicated they would welcome close relationships with the local medical society, and

WHEREAS, Efforts by many local medical societies, as a result of these district meetings and follow-up local meetings annually, have led to mutually beneficial arrangements for the dissemination of medical news,

THEREFORE, BE IT RESOLVED, That the policy of encouraging county medical societies to establish and maintain continuous cooperative relationships with local news media is hereby reiterated.

"Mr. President, the committee recommends the adoption of the substitute resolution, and I so move."

**By official action, the recommendation of the committee, namely, that the substitute resolution be adopted, was approved.**

### Amendment to the Amended Immunization Act

"This resolution was introduced by the delegates from Hamilton County and read as follows:

WHEREAS, The Ohio State Medical Association introduced a Bill to Amend Section 3313.671 of the Revised Code relative to immunization of school children; and

WHEREAS, This proposed amendment passed the House and Senate of the Ohio Assembly, therefore

BE IT RESOLVED, That the following bill be reintroduced at the next session of the Ohio State Legislature:

AN ACT

To amend section 3313.671 of the Revised Code relative to immunization of school children.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 3313.671 of the Revised Code be amended to read as follows:

Sec. 3313.671. (A) No pupil shall be admitted, at the time of his initial entry of each school year, to an elementary or high school for which the state board of education prescribes minimum standards in accordance with the provisions of division (D) of section 3301.07 of the Revised Code, unless such pupil has presented written evidence, . . . on a form prescribed by the director of health, that he has received, or is in the process of receiving, immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus by such means of immunization as may be approved by the department of health pursuant to the powers granted by section 3701.13 of the Revised Code, or unless such pupil has presented a written statement of his parent or guardian objecting to the immunization of such pupil against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus, or a statement substantiated by his physician, that such immunization is contraindicated medically. The provisions of this section shall not limit or impair the right of a board of education of a city, exempted village, or local school district to make and enforce rules or regulations to secure vaccination or immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus of the pupils under its jurisdiction . . . , provided that no child shall be required to submit to vaccination or immunization against poliomyelitis, smallpox, diphtheria, pertussis, or tetanus whose parent or guardian files a statement certifying that he is a bona fide adherent of a belief which does not accept vaccination or immunization as a means of preventing the contracting of or the spread of a communicable disease.

(B) Boards of health, legislative authorities of municipal corporations, and boards of township trustees on application of the board of education of the district or proper authority of any school affected by this section, at the public expense, without delay, shall provide the means of immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus to such pupils . . . whose parents or guardians state that they cannot afford to provide such immunizations.

Section 2. That existing section 3313.671 of the Revised Code is hereby repealed.

BE IT RESOLVED, That the legislative representatives be authorized to amend said proposed amendment to conform with the original proposed bill, if in their judgment such proposed bill can be passed at the next General Assembly of the State of Ohio.

"The committee felt that the following amendments should be made to this resolution:

"1. Have the second WHEREAS paragraph read as follows: "WHEREAS, This proposed amendment passed the House and Senate of the Ohio General Assembly but was vetoed by the Governor as contained in a veto message dated July 26, 1961.

"2. In the first resolve substitute 'a future session' for 'the next session.'

"3. That the last resolve be clarified by having it read as follows: 'That the Ohio State Medical Association legislative representatives be authorized to amend said proposed amendment to conform with the original proposed bill, if in their judgment such proposed bill can be passed at a future General Assembly of the State of Ohio.'

"Mr. President, the committee recommends the adoption of the following amended resolution, and I so move:"

### Amended Resolution on Amendment to the Amended Immunization Act

WHEREAS, The Ohio State Medical Association introduced a Bill to Amend Section 3313.671 of the Revised Code relative to immunization of school children; and

WHEREAS, This proposed amendment passed the House and Senate of the Ohio General Assembly but was vetoed

by the Governor as contained in a veto message dated July 26, 1961.

WHEREAS, This proposed amendment passed the House and Senate of the Ohio Assembly, therefore

BE IT RESOLVED, That the following bill be reintroduced at a future session of the Ohio State Legislature:

AN ACT

To amend section 3313.671 of the Revised Code relative to immunization of school children.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 3313.671 of the Revised Code be amended to read as follows:

Sec. 3313.671. (A) No pupil shall be admitted, at the time of his initial entry of each school year, to an elementary or high school for which the state board of education prescribes minimum standards in accordance with the provisions of division (D) of section 3301.07 of the Revised Code, unless such pupil has presented written evidence, . . . on a form prescribed by the director of health, that he has received, or is in the process of receiving, immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus by such means of immunization as may be approved by the department of health pursuant to the powers granted by section 3701.13 of the Revised Code, or unless such pupil has presented a written statement of his parent or guardian objecting to the immunization of such pupil against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus, or a statement substantiated by his physician, that such immunization is contraindicated medically. The provisions of this section shall not limit or impair the right of a board of education of a city, exempted village, or local school district to make and enforce rules or regulations to secure vaccination or immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus of the pupils under its jurisdiction . . . , provided that no child shall be required to submit to vaccination or immunization against poliomyelitis, smallpox, diphtheria, pertussis, or tetanus whose parent or guardian files a statement certifying that he is a bona fide adherent of a belief which does not accept vaccination or immunization as a means of preventing the contracting of or the spread of a communicable disease.

(B) Boards of health, legislative authorities of municipal corporations, and boards of township trustees on application of the board of education of the district or proper authority of any school affected by this section, at the public expense, without delay, shall provide the means of immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus to such pupils . . . whose parents or guardians state that they cannot afford to provide such immunizations.

Section 2. That existing section 3313.671 of the Revised Code is hereby repealed.

BE IT RESOLVED. That the Ohio State Medical Association legislative representatives be authorized to amend said proposed amendment to conform with the original proposed bill, if in their judgment such proposed bill can be passed at a future General Assembly of the State of Ohio.

By official action, the motion to adopt the amended resolution was approved.

## Political Action by the Medical Profession

"This resolution was introduced by the delegate from Van Wert County and read as follows:

WHEREAS, Organized Medicine and in particular its individual practitioners have traditionally stood on the side of good government, *for* the rights of the individual and his state and local governments, *for* the free and individual private enterprise system of the practice of Medicine and all other forms of business, and

WHEREAS, The events and pressures of the present and the immediate past 20 years have seemingly forced organized Medicine into an increasingly defensive and negative posture in the eyes of the press and the public as a whole, and

WHEREAS, Though by organized political action, with all the time and money implied in the term, we have won many battles only to have the specter of the welfare state rise again and again in new and ever more devious ways which demands ever increasing efforts of time and money to fight, and

WHEREAS, This continuous cycle of effort, though undeniably necessary has taken its toll of enthusiasm from those engaged in the fight, and, concomitantly, has isolated organized Medicine, in the eyes of the public and the press, more and more, and thereby placed us farther apart from the public, whom we serve and whose health is our concern by oath, and in whose behalf we are actually engaged in the battle to preserve our system of practice, and

WHEREAS, We ourselves have not been aware, or have not sufficiently expressed our awareness of our problem in relationship with the whole problem of good government and stable economy, and

WHEREAS, Our most effective spokesmen today speak individually and from the inherently more easily accepted viewpoint of private citizens exercising their right of free speech, uninfluenced by the "party line" of any Medical organization, e. g. Dr. Edward Annis, and

WHEREAS, In the current battle to defeat the King-Anderson Bill, existing organizations with positions of prestige and country-wide respect, enjoying a "favorable press," composed of representatives of *every* facet of community, business, and professional life, are battling more effectively than we, the best example of which is the Chamber of Commerce of the United States and its component state and local subsidiaries, and

WHEREAS, One can imagine a much more favorable public relations position and press, and perhaps more positive and permanent results, were we fighting not as a "vested interest" group but rather from within the combined ranks of a group composed of insurance people, Ministers, bankers, attorneys, industrial people, utility people, merchants, *etc.* and physicians, all with the common interest of furthering the cause of good government, which term includes our own just and good cause; therefore

BE IT RESOLVED, That the foregoing truths be incorporated in a review of official policy by the Council of OSMA concerning our engagement in political action as an organization, and that Council consider carefully the pros and cons of the following propositions:

(1) That organized Medicine, as such, withdraw in due course from identification with the field of political action;

(2) That our members be urged by official policy to turn their talents, time, and some of their money to individual support of the Chamber of Commerce of the United States and its subsidiaries and other like organizations, working zealously for the same objectives that Medicine has always believed in;

(3) That organized Medicine maintain an efficient information service on economic and legislative matters for its members, but that political action be carried on only by *individuals* in the roles of enlightened and free citizens, and as members and officers of organizations such as the Chamber of Commerce of the United States and its subsidiaries, which include *all* occupational groups which have common views toward the maintenance of a stable economy and good government, and further

BE IT RESOLVED. That if, after due deliberation, this departure from our current thinking be deemed by Council to have real merit, Council be empowered to use this resolution as an embarkation vehicle, to be modified, added to or substituted, according to the wisdom of Council, for the introduction of this idea at the National level.

"Our committee considered this resolution at length and unanimously recommends that it not be adopted. However, the committee and members present at the hearing were in entire agreement that we should urge members of the Ohio State Medical Association to actively support as informed citizens all organizations which direct their efforts to effect sound legislation at all levels of government affect-

ing the health and economic welfare of our nation. In addition, our own organizations should continue their legislative activities."

"Mr. President, the committee recommends that this resolution not be adopted, and I so move."

**By official action, the House of Delegates approved the recommendation of the committee that this resolution NOT be adopted.**

### Medical Care for Eye Patients

"This resolution was introduced by the delegate from Defiance County and it read as follows:

WHEREAS, The report entitled, "Medical Care for Eye Patients," adopted by the American Medical Association House of Delegates in 1961, presents a comprehensive statement of a serious problem, and,

WHEREAS, The public interest requires that the potential dangers existing in the present situation be thoroughly understood by all physicians and its significance fully recognized by the public, and,

WHEREAS, No different principle applies to the care of the patient with ocular symptoms than to any other patient, now therefore,

BE IT RESOLVED, That the care of the eye, its associate structures and the related pathways of the brain which constitute the visual system, does not call for a *lesser* training than does the practice of medicine in general, and further,

BE IT RESOLVED, That the Ohio State Medical Association concurs in the position expressed in the American Medical Association report, "Medical Care for Eye Patients," and further,

BE IT RESOLVED, That this House directs the attention of all Ohio physicians to this report, and directs that the Society distribute a copy of this resolution and a copy of the report "Medical Care for Eye Patients" to all committees, councils and other bodies of the Society and to the component county societies for their guidance in all matters pertaining to the care of eye patients and to policy in relation to eye care, and further,

BE IT RESOLVED, That a copy of this resolution and a copy of "Medical Care for Eye Patients" be forwarded to the deans of all medical schools in Ohio and the chief of staff of all hospitals in Ohio.

"On the basis of testimony heard by our committee and the content of the resolution it was clear that the intent of this resolution is educational. The committee feels that the resolution need not be adopted as the information referred to in the resolution is readily available, having been published in the November 4, 1961, issue of *The Journal of the American Medical Association*. The committee felt that calling the attention of the House of Delegates to this information would be sufficient to carry out in a practical manner the intent of the resolution.

"Mr. President, the committee recommends that this resolution not be adopted, and I so move."

**By official action, the House of Delegates approved the recommendation of the committee that this resolution NOT be adopted.**

### Nomination and Election of President-Elect

"This resolution was introduced by the delegates from Summit County and read as follows:

WHEREAS, It is the practice based on the constitution to both nominate and to elect the president of this association at the same meeting of the House of Delegates, and

WHEREAS, It is felt a constructive change would be made by nominating for the office of president-elect at one annual meeting and electing at the next annual meeting, therefore

BE IT RESOLVED, That an appropriate change be made in Article 7, Section 3 of the Constitution to effect this procedure, and further

BE IT RESOLVED, That this procedure be activated at the annual meeting of the House of Delegates in May, 1963 by nominating and electing a president-elect and also nominating at least two (2) candidates for the office to be filled by election at the annual meeting in May of 1964.

"The committee unanimously recommends that this resolution not be adopted. It is idealistic but not practical because of the length of time lapsing between the nomination and the time of the election. Furthermore, there is no practical purpose to be



*Officers, members and guests enjoyed an evening of relaxation at the President's Ball.*

served by a requirement that the delegates must always nominate two members for the office of president-elect.

"Mr. President, the committee recommends that this resolution not be adopted, and I so move."

**By official action, the House of Delegates approved the recommendation of the committee that this resolution NOT be adopted.**

### Ohio State Medical Association Staff

"This resolution was introduced by the delegates from Summit County and read as follows:

WHEREAS, It is the sincere opinion of this House that the knowledge and experience of Charles S. Nelson, Executive Secretary, Ohio State Medical Association, and his senior staff members could be well applied to innumerable county-level situations, and

WHEREAS, Conversely, this House feels a better understanding of county level needs and problems would make an even more effective state council and more functional state committees, therefore

BE IT RESOLVED, That the Council of the Ohio State Medical Association request of Mr. Nelson and receive from him by October, 1962 a plan for enlarging and developing a traveling field staff to operate under his supervision, and further

BE IT RESOLVED, That a minimum budget allocation of $30,000.00 for salaries for at least two (2) such properly qualified persons and an appropriate budget allocation for expenses be made by the proper committee and the Council for the fiscal year to begin January 1, 1963, and further,

BE IT RESOLVED, That Mr. Nelson's long range plan include assigning a staff aide for each Councilor District as funds become available.

"Because this resolution involves administrative details which should be thoroughly investigated and studied before a final decision is made, our committee recommends that this resolution be referred to The Council of the Ohio State Medical Association without recommendations."

**By official action, the House of Delegates concurred in the recommendation of the committee that this resolution be referred to The Council.**

"This resolution was introduced by the delegates from Summit County and read as follows:

### Professional Relations With Osteopathic Physicians

WHEREAS, In June, 1961 the American Medical Association House of Delegates saw fit to transfer the interpretation of the "Principles of Medical Ethics" insofar as they concerned professional association of physicians with doctors of osteopathy to the state association level, and

WHEREAS, The Council of the Ohio State Medical Association saw fit in December, 1961 to initiate change in the ethical framework for Ohio physicians by permitting, at the discretion of component county societies, professional association with osteopaths and, further, established criteria for adjudicating whether or not such associations were ethical, and

WHEREAS, This action will result in the need to administer a difficult, transitional situation at the county level, therefore,

BE IT RESOLVED, That this House of Delegates permit component societies to establish a membership classification for doctors of osteopathy at their discretion and with the approval of necessary constitutional changes by the Council of Ohio State Medical Association, and further

BE IT RESOLVED, That doctors of osteopathy not be granted membership in the Ohio State Medical Association at this time.

"The last resolution considered by our committee was the one pertaining to professional relations with osteopathic physicians. The committee recommends that this resolution not be adopted for these reasons:

"There is nothing in the Constitution and Bylaws of the Ohio State Medical Association which prohibits a county medical society from establishing a classification of membership which would include doctors of osteopathy. However, such members would not be eligible for active membership nor have the power to vote. Only doctors of medicine are eligible for membership in the Ohio State Medical Association according to our present Constitution and Bylaws.




*Dr. Horatio T. Pease accepts the office after being named President-Elect by the House of Delegates. He will assume the Presidency at the 1963 Annual Meeting in Cleveland.*

"Mr. President, the committee recommends that this resolution not be adopted, and I so move."

**By official action, the House of Delegates approved the recommendation of the committee that this resolution NOT be adopted.**

Dr. Rawling then moved that the report of Resolutions Committee No. 3 as a whole be adopted. **The House of Delegates approved the motion by official action.**

### Diligent Committee

Dr. Rawling then thanked the members of his committee for their diligent thought and effort in making this report possible. Other members of his committee were: Robert E. Howard, Hamilton County; Isador Miller, Champaign County; Donald R. Brumley, Hancock County; S. A. Burroughs, Ashtabula County; G. E. DeCicco, Mahoning County; F. W. Cook, Belmont County; Earl R. Haynes, Mus-

kingum County; George N. Spears, Lawrence County; James C. McLarnan, Knox County; Richard W. Avery, Medina County.

### Election of President-Elect

Dr. Petznick then called for the next order of business which was the nomination and election of a President-Elect.

Answering to the call for nominations, Dr. L. C. Meredith, Lorain County, placed in nomination the name of **Dr. Horatio T. Pease**, Wadsworth, a former member of The Council representing the Eleventh Councilor District. The nomination was seconded by Dr. M. D. Shilling, Ashland County.

Dr. James D. Phinney, Hamilton County, placed in nomination the name of **Dr. Charles W. Hoyt**, Cincinnati, Councilor of the First District. The nomination was seconded by Dr. Isador Miller, Champaign County.

A motion to close the nominations was then voted upon and carried.

The House of Delegates ballotted on Dr. Pease and Dr. Hoyt. Dr. William A. White, Jr., Stark County, chairman of the Committee on Tellers and Judges of Election, reported to the president that the voting had resulted as follows: Dr. Pease, 92 votes and Dr. Hoyt, 61 votes.

President Petznick then declared Dr. Pease duly elected President-Elect of the Ohio State Medical Association for the ensuing year. Dr. Pease was escorted to the rostrum and following an ovation from the House of Delegates spoke briefly pledging his wholehearted efforts to the programs and activities of the Association.

### Election of Councilors

The report of the Nominating Committee was presented by Dr. Daniel V. Jones, Hamilton County, chairman of that committee.

#### First District

As Councilor of the First District to succeed Dr. Charles W. Hoyt, Cincinnati, who asked that his name not be presented for re-election to The Council, the committee placed in nomination the name of **Dr. Robert E. Howard**, Cincinnati, to serve for a term of two years. There being no further nominations from the floor, by official action the nominations were closed and Dr. Howard was declared elected Councilor of the First District for a term of two years, 1962-1963 and 1963-1964.

#### Second District

The committee placed in nomination the name of **Dr. George J. Schroer**, Sidney, as a member of The Council from the Second District to serve for one year — the unexpired term of Dr. Ray M. Turner, Springfield, who resigned as a member of The Council for reasons of health. There being no further nominations from the floor, by official action the nominations were closed and Dr. Schroer was declared elected Councilor of the Second District for one year — 1962-1963.

#### Third District

The committee placed in nomination the name of **Dr. Floyd M. Elliott**, Ada, to succeed himself as a member of The Council from the Third District for a term of two years. There being no further nominations from the floor, by official action the nominations were closed and Dr. Elliott was declared elected Councilor of the Third District for a term of two years, 1962-1963 and 1963-1964.

#### Fifth District

The committee placed in nomination the name of **Dr. Henry A. Crawford**, Cleveland, to succeed himself as a member of The Council from the Fifth District for a term of two years. There being no further nominations from the floor, by official action the nominations were closed and Dr. Crawford was declared elected Councilor of the Fifth District for a term of two years, 1962-1963 and 1963-1964.

#### Seventh District

The committee placed in nomination the name of **Dr. Benjamin C. Diefenbach**, Martins Ferry, to succeed himself as a member of The Council from the Seventh District for a term of two years. There being no further nominations from the floor, by official action the nominations were closed and Dr. Diefenbach was declared elected Councilor of the Seventh District for a term of two years, 1962-1963 and 1963-1964.

#### Ninth District

The committee placed in nomination the name of **Dr. Chester H. Allen**, Portsmouth, to succeed himself as a member of The Council from the Ninth District for a term of two years. There being no further nominations from the floor, by official action the nominations were closed and Dr. Allen was declared elected Councilor of the Ninth District for a term of two years, 1962-1963 and 1963-1964.

#### Eleventh District

The committee placed in nomination the name of **Dr. Lawrence C. Meredith**, Elyria, to succeed himself as a member of The Council from the Eleventh District for a term of two years. There being no further nominations from the floor, by official action the nominations were closed and Dr. Meredith was declared elected Councilor of the Eleventh District for a term of two years — 1962-1963 and 1963-1964.

### AMA Delegates and Alternates

The Nominating Committee then presented nominations for the offices of delegate and alternate to the American Medical Association.

To succeed Dr. Charles L. Hudson, Cleveland,

delegate, for the balance of 1962, Dr. Hudson having resigned due to the fact that he is a member of the Board of Trustees of the AMA, the committee placed in nomination the name of Dr. Frederick P. Osgood, Toledo.

Dr. Edwin H. Artman, Chillicothe, placed in nomination the name of Dr. George W. Petznick, Cleveland, for the unexpired term of Dr. Hudson.

A ballot being called for, the House of Delegates balloted on the names of Dr. Osgood and Dr. Petznick. Dr. White, chairman of the Committee on Tellers and Judges of Election, announced that the balloting had resulted as follows: Dr. Petznick, 74 votes and Dr. Osgood, 72 votes.

Dr. Hamwi, president-elect, then in the chair, announced the election of Dr. George W. Petznick, Shaker Heights, to serve as delegate in place of Dr. Hudson for the balance of 1962.



*Dr. George W. Petznick, left, receives the Past-President's button from Dr. Edwin H. Artman, Chillicothe, who retires from The Council after serving a year as Immediate Past-President.*

The Nominating Committee then nominated Dr. Osgood as delegate to the American Medical Association for a term of two years, effective January 1, 1963.

Dr. Artman placed in nomination the name of Dr. Petznick to serve as a delegate to the AMA for a term of two years, effective January 1, 1963.

At this point Dr. Osgood gained recognition of the chair and asked permission to withdraw his name as a nominee. Permission being granted and there being no further nominations, the nominations were closed and Dr. Petznick was declared elected delegate to the AMA for a term of two years beginning January 1, 1963.

The Nominating Committee then placed in nomination the name of Dr. H. T. Pease, Wadsworth, as alternate-delegate to Dr. George W. Petznick, Cleveland, for a term of two years beginning January 1, 1963. There being no further nominations from the floor, by official action the nominations were closed and Dr. Pease was declared elected alternate-delegate to Dr. Petznick for a term of two years beginning January 1, 1963.

Dr. Carl A. Lincke, Carrollton, and Dr. Robert S. Martin, Zanesville, were nominated by the committee as delegate and alternate, respectively. There being no further nominations from the floor, by official action the nominations were closed and Dr. Lincke was declared elected delegate and Dr. Martin was declared elected his alternate to the AMA for a term of two years beginning January 1, 1963.

Dr. George A. Woodhouse, Pleasant Hill, and Dr. T. L. Light, Dayton, were nominated by the committee as delegate and alternate respectively. There being no further nominations from the floor, by official action the nominations were closed and Dr. Woodhouse was declared elected delegate and Dr. Light was declared elected his alternate to the AMA for a term of two years beginning January 1, 1963.

The Nominating Committee then placed in nomination the name of Dr. Edmond K. Yantes, Wilmington, as delegate for a term of two years, effective January 1, 1963. There being no further nominations from the floor, by official action the nominations were closed and Dr. Yantes was declared elected delegate to the AMA for a term of two years beginning January 1, 1963.

As alternate-delegate to Dr. Yantes the committee nominated Dr. Harry K. Hines, Cincinnati, to serve for the balance of 1962 and for a term of two years beginning January 1, 1963, succeeding Dr. Fred W. Dixon, Cleveland, who requested that his name not be placed in nomination. There being no further nominations from the floor, by official action the nominations were closed and Dr. Hines was declared elected alternate-delegate to Dr. Yantes for the balance of 1962 and for a term of two years beginning January 1, 1963.

### Inaugural Ceremony

Dr. Petznick then asked that all of the newly elected officers, councilors, delegates and alternates come to the rostrum. They appeared at the rostrum and were officially installed into office by Dr. Petznick.

Dr. Petznick presented the official gavel of the Association to Dr. Hamwi, the incoming President, and extended to him best wishes for success during the ensuing year.

After he took office Dr. Hamwi presented Dr. Petznick with the official past-president's button. Dr. Hamwi then addressed the House of Delegates. (See page 801 for Dr. Hamwi's remarks.)

Dr. Hamwi paid tribute to Doctors Charles W. Hoyt, Cincinnati, and Ray M. Turner, Springfield,

retiring Councilors of the First and Second Districts, respectively, and each received an ovation from the House of Delegates.

### Committees Named

The following committee appointments were made by Dr. Hamwi and were officially approved by the House of Delegates:

Committee on Education — Dr. Robert H. Kotte, Cincinnati, reappointed for a term of five years. Dr. Thomas E. Rardin, Columbus, a member of the committee, reappointed chairman for the ensuing year.

Judicial and Professional Relations Committee — Dr. A. C. Ormond, Zanesville, reappointed for a term of five years. Dr. Frank F. A. Rawling, Toledo, a member of the committee, reappointed chairman for the ensuing year.

Committee on Public Relations and Economics — Dr. John J. Cranley, Jr., Cincinnati, appointed for a term of five years. Dr. Frederick P. Osgood, Toledo, a member of the committee, reappointed chairman for the ensuing year.

Committee on Scientific Work — Dr. F. A. Simeone, Cleveland, reappointed for a term of five years and Dr. William Hamelberg, Columbus, appointed for a term of five years. Dr. Maurice A. Schnitker, Toledo, a member of the committee, reappointed chairman for the ensuing year.

### New Business

Dr. John J. Grady, Cleveland, under the item of new business, offered a motion expressing appreciation on behalf of the Ohio State Medical Association to all who had any part in the 1962 Annual Meeting or preparing for it, including the members of the Columbus Academy of Medicine and their wives, the various state and local committees, members of the press, radio and TV, managements of the Columbus hotels and the management of the Veterans Memorial Building. The motion was adopted unanimously by the House of Delegates.

Dr. Hamwi announced that the 1963 Annual Meeting would be held in Cleveland, the week of May 12.

The House of Delegates then adjourned sine die.

Attest: CHARLES S. NELSON,
*Executive Secretary.*

## ROLL CALL OF HOUSE OF DELEGATES. 1962 ANNUAL MEETING

| County | Delegate | First Session | Second Session |
|---|---|---|---|
| | **FIRST DISTRICT** | | |
| ADAMS | Robert B. Ellison | Present | Present |
| BROWN | Charles H. Maly | ..... | ..... |
| BUTLER | John A. Carter | Present | Present |
| | Paul N. Ivins | Present | Present |
| CLERMONT | Donald K. Ebersold | Present | Present |
| CLINTON | Edmond K. Yantes | Present | Present |
| HAMILTON | Frank P. Cleveland | Present | Present |
| | Joseph G. Crotty | Present | Present |
| | Neal N. Earley | Present | Present |
| | David L. Graller | Present | Present |
| | Harry K. Hines | Present | Present |
| | Robert E. Howard | Present | Present |
| | Daniel V. Jones | Present | Present |
| | Carl W. Koehler | Present | ..... |
| | William A. Moore | Present | Present |
| | James D. Phinney | ..... | Present |
| | Isadore C. Sharon | Present | Present |
| | Calvin F. Warner | Present | Present |
| | Edward Woliver | Present | Present |
| HIGHLAND | J. Martin Byers | Present | Present |
| WARREN | Thomas E. Fox | Present | Present |
| | **SECOND DISTRICT** | | |
| CHAMPAIGN | Isador Miller | Present | Present |
| CLARK | Robert A. McLemore | Present | Present |
| | J. Harold Shanklin | Present | Present |
| DARKE | Maurice M. Kane | Present | Present |
| GREENE | Roger C. Henderson | Present | Present |
| MIAMI | David M. Spencer | Present | Present |
| MONTGOMERY | Kenneth D. Arn | Present | Present |
| | A. V. Black | ..... | Present |
| | Robert A. Bruce | Present | Present |
| | Theodore L. Light | Present | Present |
| | J. Richard Strawsburg | Present | ..... |
| | James G. Tye | Present | Present |
| | Sylvan L. Weinberg | Present | Present |
| PREBLE | Chester J. Brian | Present | Present |
| SHELBY | George J. Schroer | Present | Present |
| | **THIRD DISTRICT** | | |
| ALLEN | Dwight L. Becker | Present | Present |
| | Fred P. Berlin | Present | Present |
| AUGLAIZE | Elizabeth Y. Kuffner | Present | Present |
| CRAWFORD | Martin M. Horowitz | Present | Present |
| HANCOCK | Donald R. Brumley | Present | Present |
| HARDIN | C. L. Johnson | Present | Present |
| LOGAN | Hobart L. Mikesell | Present | Present |
| MARION | Frederick T. Merchant | Present | Present |
| MERCER | Donald R. Fox | ..... | ..... |
| SENECA | Emmet T. Sheeran | ..... | Present |
| VAN WERT | Edwin W. Burnes | Present | ..... |
| WYANDOT | T. R. Huston | ..... | Present |
| | **FOURTH DISTRICT** | | |
| DEFIANCE | Charles E. Jaeckle | Present | Present |
| FULTON | Benjamin H. Reed, Jr. | Present | Present |
| HENRY | Thomas F. Tabler | Present | Present |
| LUCAS | Edmond F. Glow | Present | Present |
| | William G. Henry | Present | Present |
| | Edward F. Ockuly | Present | Present |
| | Frederick P. Osgood | Present | Present |
| | Frank F. A. Rawling | Present | Present |
| | Max T. Schnitker | Present | Present |
| OTTAWA | George A. Boon | Present | Present |
| PAULDING | D. E. Farling | Present | Present |
| PUTNAM | Milo B. Rice | Present | ..... |
| SANDUSKY | Robert A. Borden | Present | Present |
| WILLIAMS | Robert W. Dilworth | ..... | Present |
| WOOD | Paul F. Orr | Present | Present |
| | **FIFTH DISTRICT** | | |
| ASHTABULA | Shepard A. Burroughs | Present | Present |
| CUYAHOGA | Joseph C. Avellone | Present | Present |
| | James O. Barr | Present | Present |
| | Joseph L. Bilton | Present | Present |
| | William F. Boukalik | Present | Present |
| | John H. Budd | Present | Present |
| | E. Peter Coppedge | Present | ..... |
| | E. H. Crawfis | Present | ..... |
| | Russell B. Crawford | Present | Present |
| | Nicholas G. DePiero | .... | Present |
| | William E. Forsythe | Present | Present |
| | John G. Grady | Present | Present |
| | John R. Hasserick | .... | Present |
| | Charles L. Hudson | Present | Present |

*(Continued on Page 820)*

(Continued from Page 819)

| County | Delegate | First Session | Second Session |
|---|---|---|---|
| | Chester R. Jablonoski | Present | Present |
| | Fred R. Kelly | Present | Present |
| | M. H. Lambright | Present | Present |
| | Charles L. Leedham | Present | Present |
| | L. Philip Longley | .... | Present |
| | L. J. McCormack | Present | Present |
| | Paul A. Mielcarek | Present | .... |
| | Russell P. Rizzo | Present | Present |
| | P. John Robechek | Present | Present |
| | John H. Sanders | .... | Present |
| | A. Benedict Schneider | Present | Present |
| | E. C. Weckesser | Present | .... |
| GEAUGA | Alton W. Behm | .... | .... |
| LAKE | Benjamin S. Park | Present | Present |
| | **SIXTH DISTRICT** | | |
| COLUMBIANA | John A. Fraser | Present | Present |
| MAHONING | G. E. DeCicco | Present | Present |
| | Paul J. Mahar | Present | Present |
| | John J. McDonough | Present | Present |
| | Harlan P. McGregor | Present | Present |
| PORTAGE | Edward A. Webb | Present | Present |
| STARK | Maurice F. Lieber | Present | Present |
| | Ralph K. Ramsayer | Present | Present |
| | Clarence V. Smith | Present | Present |
| | William A. White, Jr. | Present | Present |
| SUMMIT | Arthur Dobkin | .... | Present |
| | Walter A. Hoyt, Jr. | Present | Present |
| | Leonard V. Phillips | Present | Present |
| | Ed. A. Riemenschneider | Present | .... |
| | James G. Roberts | Present | Present |
| | Fred F. Somma | Present | Present |
| | Paul L. Weygandt | Present | Present |
| TRUMBULL | Raymond Ralston | Present | Present |
| | Edwin R. Westbrook | Present | Present |
| | **SEVENTH DISTRICT** | | |
| BELMONT | Fred W. Cook | Present | Present |
| CARROLL | Glenn C. Dowell | Present | Present |
| COSHOCTON | Robert R. Johnson | Present | Present |
| HARRISON | Elias Freeman | Present | Present |
| JEFFERSON | Stanley L. Burkhardt | .... | Present |
| | Carl F. Goll | Present | .... |
| MONROE | Byron Gillespie | .... | .... |
| TUSCARAWAS | Robert E. Rinderknecht | Present | Present |
| | **EIGHTH DISTRICT** | | |
| ATHENS | Ruth Matthewson | Present | .... |
| FAIRFIELD | Jack L. Kraker | Present | Present |
| GUERNSEY | James A. L. Toland | .... | Present |
| LICKING | Jay R. Wells | Present | Present |
| MORGAN | Henry Bachman | .... | Present |
| MUSKINGUM | Earl R. Haynes | Present | Present |
| NOBLE | Edward G. Ditch | .... | .... |
| PERRY | Alton J. Ball | Present | Present |
| WASHINGTON | Kenneth E. Bennett | Present | Present |
| | **NINTH DISTRICT** | | |
| GALLIA | Oscar W. Clarke | Present | Present |
| HOCKING | Owen F. Yaw | .... | .... |
| JACKSON | Clarence C. Fitzpatrick | Present | Present |
| LAWRENCE | George N. Spears | Present | Present |
| MEIGS | Roger P. Daniels | Present | Present |
| PIKE | Robert T. Leever | .... | .... |
| SCIOTO | J. R. Sheets | Present | Present |
| VINTON | Richard E. Bullock | .... | .... |
| | **TENTH DISTRICT** | | |
| DELAWARE | Adelbert R. Callander | Present | Present |
| FAYETTE | Byers W. Shaw | Present | Present |
| FRANKLIN | Drew J. Arnold | Present | Present |
| | William F. Bradley | Present | Present |
| | William H. Carter | Present | Present |
| | Mel A. Davis | Present | Present |
| | Richard L. Fulton | Present | Present |
| | Thomas M. Hughes | Present | Present |
| | Charles W. Pavey | Present | Present |
| | Alexander Pollack | Present | .... |
| | Allen D. Puppel | .... | Present |
| KNOX | James C. McLarnan | Present | Present |
| MADISON | Sol Maggied | Present | Present |
| MORROW | Joseph P. Ingmire | Present | Present |
| PICKAWAY | J. M. Hedges | Present | Present |
| ROSS | Robert E. Swank | Present | Present |
| UNION | E. J. Marsh | Present | Present |
| | **ELEVENTH DISTRICT** | | |
| ASHLAND | Myrle D. Shilling | Present | Present |
| ERIE | Emil J. Meckstroth | Present | Present |
| HOLMES | Neven P. Stauffer | Present | Present |
| HURON | O. J. Nicholson | Present | Present |
| LORAIN | John W. Newman | Present | Present |
| | James T. Stephens | Present | Present |
| MEDINA | Richard W. Avery | Present | Present |
| RICHLAND | James O. Ludwig | Present | Present |
| | William R. Roasberry | Present | Present |
| WAYNE | Albert B. Huff | Present | Present |
| | **OFFICERS** | | |
| President | George W. Petznick | Present | Present |
| President-Elect | Geo. J. Hamwi | Present | Present |
| Past-President | Edwin H. Artman | Present | Present |
| Treasurer | Philip B. Hardymon | Present | Present |
| | **COUNCILORS** | | |
| First | Charles W. Hoyt | Present | Present |
| Second | Ray M. Turner | Present | Present |
| Third | Floyd M. Elliott | Present | Present |
| Fourth | Edwin R. Murbach | Present | Present |
| Fifth | Henry A. Crawford | Present | Present |
| Sixth | R. E. Tschantz | Present | Present |
| Seventh | B. C. Diefenbach | Present | Present |
| Eighth | Robert C. Beardsley | Present | Present |
| Ninth | Chester H. Allen | Present | Present |
| Tenth | Robert M. Inglis | Present | Present |
| Eleventh | Lawrence C. Meredith | Present | Present |
| | Totals | 155 | 157 |

## Ohioans Will Participate In Chicago Program

Three Ohioans are listed in the program announced by the Interstate Postgraduate Medical Association of North America for October 1-4, at the Palmer House in Chicago.

Dr. George J. Hamwi, Columbus, President of the Ohio State Medical Association, and professor of medicine at Ohio State University, will discuss "New Information on Thyroid Disease."

Dr. Robert M. Zollinger, Columbus, chief of surgery at Ohio State University College of Medicine, will talk on "Sedatives, Antibiotics and Cathartics."

Dr. Leonard L. Lovshin, Cleveland, will discuss "Emotional Disorders which Can Be Best Managed by the Family Physician."

## Cleveland Will Receive Grant for Clinical Research Center

University Hospitals of Cleveland, associated with Western Reserve University College of Medicine, will receive a grant of $600,000 for a new general clinical research center awarded by the Division of General Medical Research of the National Institutes of Health. The grant is one of 10 awarded to medical schools and research hospitals, totaling $4,201,846. The grants will bring to 50 the number of General Clinical Research Centers established through the Division of General Medical Sciences under a program authorized by Congress in 1960.

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The Middle States Public Health Association, at its meetings in Minneapolis recently, adopted a resolution against the King Anderson Bill, H.R. 4222.

# Annual Meeting Attendance . . .

## Here Are Figures on How Many Were Present at the Meeting; Members, Other Physicians, Guests, etc.

REPORTS from the 1962 Annual Meeting in Columbus show that an excellent attendance was recorded and there was a good turnout of members, guest physicians, medical students, and other guests. Total registration was 3019 with the following breakdown: Members, 1304; guest physicians, 265; medical students, 343; Woman's Auxiliary, and miscellaneous guests including nurses, technicians, dentists, etc., 736; scientific and technical exhibitors, 371.

Following are registration figures for members of the Association by counties and a comparison of Annual Meeting attendance figures from 1919 through 1962:

### Registration by Counties, 1962 Annual Meeting, and Membership Data

| County | Total Membership Dec. 31, 1961 | Total Membership May 14, 1962 | Annual Meeting Registration |
|---|---|---|---|
| Adams | 10 | 11 | 3 |
| Allen | 118 | 118 | 22 |
| Ashland | 27 | 26 | 3 |
| Ashtabula | 59 | 55 | 3 |
| Athens | 34 | 33 | 3 |
| Auglaize | 18 | 19 | 4 |
| Belmont | 55 | 55 | 7 |
| Brown | 15 | 15 | 1 |
| Butler | 167 | 165 | 20 |
| Carroll | 9 | 9 | 3 |
| Champaign | 16 | 16 | 2 |
| Clark | 123 | 126 | 25 |
| Clermont | 27 | 27 | 2 |
| Clinton | 26 | 24 | 6 |
| Columbiana | 72 | 73 | 9 |
| Coshocton | 27 | 26 | 7 |
| Crawford | 37 | 36 | 8 |
| Cuyahoga | 2158 | 2111 | 149 |
| Darke | 25 | 26 | 6 |
| Defiance | 21 | 21 | 2 |
| Delaware | 26 | 27 | 10 |
| Erie | 66 | 63 | 10 |
| Fairfield | 51 | 52 | 17 |
| Fayette | 16 | 16 | 4 |
| Franklin | 865 | 824 | 327 |
| Fulton | 21 | 21 | 3 |
| Gallia | 33 | 31 | 4 |
| Geauga | 13 | 17 | 1 |
| Greene | 44 | 44 | 9 |
| Guernsey | 35 | 30 | 1 |
| Hamilton | 1188 | 1173 | 87 |
| Hancock | 42 | 41 | 7 |
| Hardin | 22 | 25 | 4 |
| Harrison | 8 | 8 | 3 |
| Henry | 15 | 16 | 2 |
| Highland | 20 | 20 | 7 |
| Hocking | 11 | 11 | 2 |
| Holmes | 10 | 9 | 3 |
| Huron | 26 | 27 | 5 |
| Jackson | 16 | 12 | 4 |
| Jefferson | 62 | 46 | 6 |
| Knox | 36 | 35 | 8 |
| Lake | 87 | 94 | 4 |
| Lawrence | 26 | 25 | 5 |
| Licking | 59 | 58 | 19 |
| Logan | 22 | 20 | 5 |
| Lorain | 169 | 167 | 17 |
| Lucas | 604 | 584 | 43 |
| Madison | 14 | 13 | 5 |
| Mahoning | 325 | 331 | 35 |
| Marion | 66 | 57 | 11 |
| Medina | 47 | 49 | 10 |
| Meigs | 6 | 6 | 1 |
| Mercer | 24 | 22 | 2 |
| Miami | 57 | 58 | 12 |
| Monroe | 3 | 4 | ... |
| Montgomery | 523 | 511 | 86 |
| Morgan | 3 | 2 | 1 |
| Morrow | 8 | 8 | 5 |
| Muskingum | 64 | 61 | 9 |
| Noble | 4 | 4 | ... |
| Ottawa | 19 | 20 | 3 |
| Paulding | 9 | 8 | 1 |
| Perry | 10 | 11 | 3 |
| Pickaway | 15 | 14 | 6 |
| Pike | 11 | 11 | 1 |
| Portage | 52 | 52 | 6 |
| Preble | 10 | 11 | 3 |
| Putnam | 13 | 14 | 3 |
| Richland | 109 | 109 | 24 |
| Ross | 46 | 42 | 17 |
| Sandusky | 43 | 40 | 4 |
| Scioto | 71 | 72 | 11 |
| Seneca | 52 | 47 | 9 |
| Shelby | 21 | 21 | 7 |
| Stark | 352 | 347 | 21 |
| Summit | 520 | 535 | 42 |
| Trumbull | 131 | 126 | 12 |
| Tuscarawas | 56 | 53 | 13 |
| Union | 16 | 17 | 6 |
| Van Wert | 19 | 18 | 3 |
| Vinton | 2 | 2 | 1 |
| Warren | 16 | 16 | 2 |
| Washington | 30 | 30 | 7 |
| Wayne | 58 | 56 | 12 |
| Williams | 19 | 19 | 3 |
| Wood | 36 | 37 | 2 |
| Wyandot | 13 | 13 | 5 |
| Totals | 9530 | 9355 | 3019 |

### ANNUAL MEETING REGISTRATION FOR 1919-1962 INCLUSIVE

| Year | Place | Members | Guest Physicians | Medical Students | Woman's Aux.; Misc. Guests | Sc. and Tech. Exhibitors | Total |
|---|---|---|---|---|---|---|---|
| 1919 | Columbus | 1173 | | | 264 | 92 | 1539 |
| 1920 | Toledo | 860 | | | 105 | 80 | 1062 |
| 1921 | Columbus | 1275 | | | 104 | 96 | 1503 |
| 1922 | Cincinnati | 1066 | | | 184 | 70 | 1341 |
| 1923 | Dayton | 1117 | | | 202 | 76 | 1414 |
| 1924 | Cleveland | 1301 | | | 180 | 109 | 1603 |
| 1925 | Columbus | 1204 | | | 361 | 107 | 1689 |
| 1926 | Toledo | 903 | | | 120 | 83 | 1125 |
| 1927 | Columbus | 1320 | | | 286 | 82 | 1705 |
| 1928 | Cincinnati | 916 | | | 92 | 80 | 1115 |
| 1929 | Cleveland | 1231 | | | 249 | 124 | 1619 |
| 1930 | Columbus | 1241 | | | 435 | 86 | 1775 |
| 1931 | Toledo | 826 | | | 198 | 50 | 1087 |
| 1932 | Dayton | 978 | | | 201 | 45 | 1226 |
| 1933 | Akron | 858 | | | 160 | 25 | 1049 |
| 1934 | Columbus | 1069 | | | 410 | 51 | 1539 |
| 1935 | Cincinnati | 973 | | | 197 | 84 | 1271 |
| 1936 | Cleveland | 1099 | | | 563 | 137 | 1813 |
| 1937 | Dayton | 1103 | | | 366 | 64 | 1551 |
| 1938 | Columbus | 1330 | | | 619 | 104 | 2068 |
| 1939 | Toledo | 1056 | | | 271 | 84 | 1426 |
| 1940 | Cincinnati | 1126 | | | 323 | 114 | 1589 |
| 1941 | Cleveland—Joint Meeting with A.M.A. | | | | | | |
| 1942 | Columbus | 1221 | | | 527 | 119 | 1880 |
| 1943 | Columbus | 544 | | | 160 | | 717 |
| 1944 | Columbus | 830 | | | 441 | 130 | 1421 |
| 1945 | No Meeting | | | | | | |
| 1946 | Columbus | 1262 | 130 | 65 | 507 | 507 | 2121 |
| 1947 | Cleveland | 1502 | 158 | 15 | 411 | 328 | 2414 |
| 1948 | Cincinnati | 1362 | 293 | 27 | 491 | 214 | 2387 |
| 1949 | Columbus | 1533 | 162 | 221 | 462 | 230 | 2608 |
| 1950 | Cleveland | 1587 | 260 | 102 | 707 | 376 | 3032 |
| 1951 | Cincinnati | 1208 | 162 | 185 | 647 | 352 | 2554 |
| 1952 | Cleveland | 1366 | 204 | 49 | 687 | 395 | 2701 |
| 1953 | Cincinnati | 1155 | 180 | 224 | 578 | 298 | 2435 |
| 1954 | Columbus | 1222 | 197 | 173 | 701 | 252 | 2545 |
| 1955 | Cincinnati | 1360 | 211 | 184 | 738 | 317 | 2810 |
| 1956 | Cleveland | 1601 | 338 | 120 | 1029 | 489 | 3577 |
| 1957 | Columbus | 1164 | 149 | 320 | 689 | 368 | 2690 |
| 1958 | Cincinnati | 1327 | 164 | 45 | 674 | 325 | 2535 |
| 1959 | Columbus | 1359 | 293 | 445 | 721 | 364 | 3182 |
| 1960 | Cleveland | 1642 | 489 | 48 | 1026 | 447 | 3652 |
| 1961 | Cincinnati | 1256 | 231 | 24 | 751 | 301 | 2563 |
| 1962 | Columbus | 1304 | 265 | 343 | 736 | 371 | 3019 |

# Annual Meeting in Review . . .

## Presented Here Are Highlights and Sidelights That Combined To Make a Successful Session

VOLUMES could be written on the 1962 Annual Meeting and on the many persons who participated in the program, served on committees and otherwise made the session a success. This resumé is given merely to touch upon some events and to attempt to give an over-all view of the meeting. Official reports of proceedings during the meeting are printed elsewhere under respective headings. The table of contents beginning on the inside front cover is a ready reference to page numbers of reports. Candid photographs taken at random during the meeting highlight some of the events and add personal touches. Following are items of interest to members:

### President's Ball

This social event of the Annual Meeting was enjoyed by members and guests in the Grand Ballroom of the Neil House on Wednesday evening. Following the cocktail hour a buffet dinner was served and dinner dancing was enjoyed.

Special entertainment was furnished by the Buckeye Chorus of the Society for the Preservation and Encouragement of Barber Shop Quartet Singing in America, Inc., under direction of Kenneth R. Keller. This group of fine singers brought a standing ovation from the audience.

### Committeemen Named

One of the initial duties of the Incoming President is that of appointing, with the consent of Council, members to the numerous standing and special committees of the Association. The new roster of these committeemen, together with a list of officers, Councilors and AMA delegates, is published elsewhere in this issue under the title "State Association Officers and Committeemen."

Members of Committees of the House of Delegates are named in the Proceedings of the House.

The roster of these committees and their membership is a cue to the extent and variety of activities that go into the Association's Workload.

### Past-Presidents Honored

Past-Presidents of the Association were honored guests with their wives at a social hour and dinner given by The Council on Tuesday evening, the week of the Annual Meeting. Elsewhere in this issue is a photograph taken of Past-Presidents present for the event. Other guests were officers of medical associations from neighboring states, also members of the OSMA executive staff and their wives.

### Outstanding Exhibits

The exhibit floor of the Veterans Memorial Building furnished an appropriate setting for an array of excellent Scientific and Educational Exhibits. Selection was made of seven exhibits to receive special recognition, with gold, silver and bronze awards in



*Members and guests at the President's Ball were entertained by the Buckeye Chorus of SPEBSQSA—The Society for the Preservation and Encouragement of Barber Shop Quartet Singing in America, Inc. Kenneth R. Keller is directing the group.*

# One of Many Groups at the President's Ball




*One of the many groups of officers, members and guests seen at the President's Ball on Wednesday evening.*

the fields of teaching and of original investigation. A certificate of merit also was awarded. See special article on the Exhibits for pictures of these award winners.

### Technical Exhibits

One of the excellent features of the Annual Meeting was the array of Technical Exhibits which occupied much of the exhibit floor of the Veterans Memorial Building. Here members had an opportunity to talk face to face with detail men from pharmaceutical and other supply houses on the latest developments in the supply field. From the many comments made by members, and exhibitors as well, this feature was a successful affair from beginning to end.

### Psychiatrists Elect

The Ohio Psychiatric Association conducted a program as a feature of the OSMA Annual Meeting. During the session the organization held a brief business meeting and elected officers. Following are the officers for the current year: Dr. Philip E. Piker, Cincinnati, president; Dr. Irving Pine, Columbus, president-elect; Dr. Irvin N. Perr, Cleveland Regional Treatment Center, E. 124th St. and Fairhill Rd., Cleveland 20, secretary-treasurer.

### News Coverage

The Annual Meeting was widely reported by the news media. Newspaper, radio and television use of news releases sent out in advance of the meeting, and following the meeting, was extensive. Further, day-by-day news stories were used extensively.

Among news media representatives covering the sessions were the following: Mary McGarey, Johnny Jones and Gordon Kuster, Jr., of *The Columbus Dispatch;* Don Dunham of *The Cleveland Press and News;* Karl Abraham of *The Cleveland Plain Dealer;* Ray Bruner of *The Toledo Blade;* John Bird of *The Akron Beacon-Journal;* Oliver Brown, Jr., of *The Dayton Daily News;* Jack Smith of *The Cincinnati Enquirer;* Adrienne Block and Barbara Froelich of the Associated Press; Dave Collins, WRFD, Columbus; Nick Basso, WTVN-TV, Colubus.

### The Art Exhibit

The Physicians' Art Exhibit was another feature of the meeting. Many doctors displayed paintings, photographs, wood carvings and other forms of art work.

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## $146,175 Given Ohio State College of Medicine

The Ohio State University College of Medicine has received $146,175 from the National Institute of Health to support the training of medical students and graduate physicians in research methods in the field of endocrinology and metabolism.

Dr. Geo. J. Hamwi, professor of medicine and chief of the endocrinology and metabolism service at the University Hospitals and President of OSMA, said the funds provide for three traineeships for medical students and two post-doctoral fellowships for graduate physicians over the next five years.

# Exhibits in Review . . .

## Outstanding Displays from Fields of Teaching And Original Investigation Receive Recognition

THE Scientific and Educational Exhibit again was one of the areas of continued interest during the Annual Meeting. Displayed in a section of the Veterans Memorial Building Exhibit Hall, 36 booths depicted recent findings in the fields of original investigation, teaching and some special fields. A committee was named to review the exhibits and to designate those considered to be outstanding in their respective fields. Gold, silver and bronze awards were given in the fields of teaching and original investigation. Also a certificate of merit was awarded one exhibit team.

As usual the exhibit area was a busy place during the Annual Meeting and members found particular interest in talking to respective sponsors who took turns manning the booths during the three-day showing.



*Gold Award Winner in the Teaching Field: The exhibit "Surgery of the Breast," sponsored by Dr. Joseph A. Bonta and Dr. Arthur G. James, Columbus.*

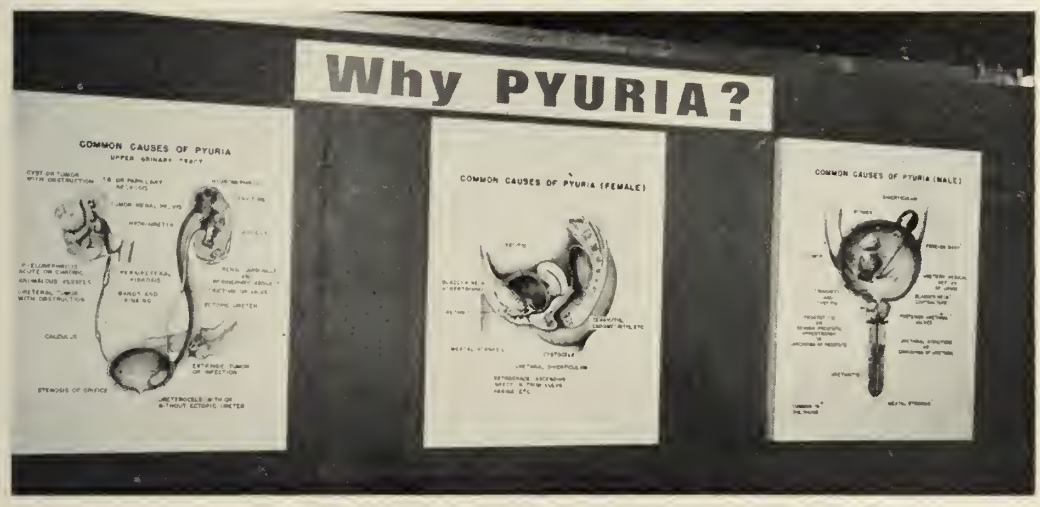



*Gold Award winner in the Field of Original Investigation: The exhibit "Controlled Hypotension with Sodium Nitroprusside," sponsored by Drs. Elmars M. Bitte, Patrick P. Moraca, Donald E. Hale, Carl E. Wasmuth and Eugene F. Poutasse, of the Cleveland Clinic.*

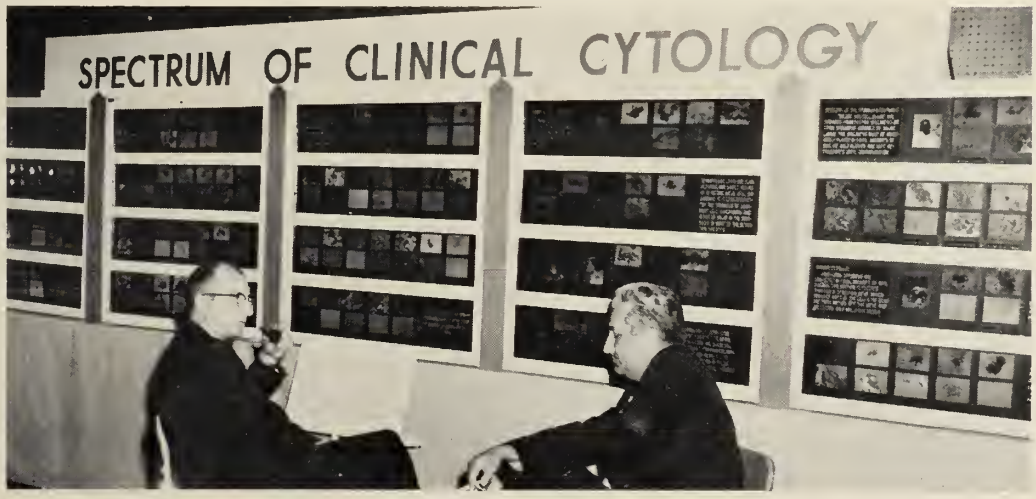
# Scientific Exhibits Receive Honors




*Silver Award winner in Original Investigation: The exhibit, "Hereditary Hemorrhagic Telangiectasia," sponsored by Dr. William H. Saunders, Department of Otolaryngology, Ohio State University College of Medicine.*

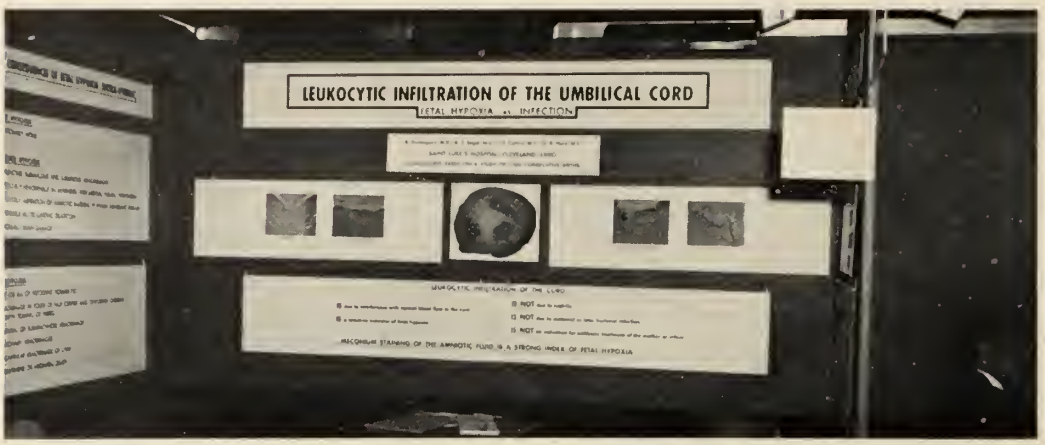



*Silver Award winner in the Teaching field: The exhibit "Why Pyuria?" sponsored by the Department of Urology, University of Cincinnati College of Medicine. Dr. Arthur T. Evans, director.*

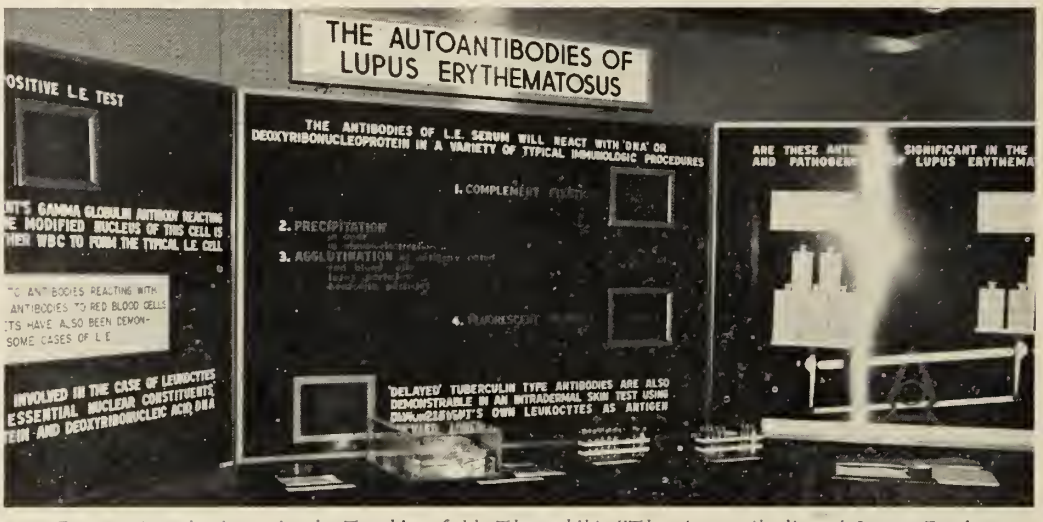



*Certificate of Merit was awarded the exhibit, "Spectrum of Clinical Cytology," sponsored by Dr. Emmerich von Haam, Ohio State University Medical Center, Columbus, and the National Institutes of Health, Bethesda, Md.*

# Additional Outstanding Exhibits




*Bronze Award winner in Original Investigation: The exhibit "Leukocytic Infiltration of the Umbilical Cord — Fetal Hypoxia vs. Infection," sponsored by Drs. R. Dominguez, A. J. Segal, J. R. Collins, G. B. Hurd, of Saint Luke's Hospital, Cleveland.*




*Bronze Award winner in the Teaching field: The exhibit "The Autoantibodies of Lupus Erythematosus," sponsored by Donald J. Blaney, Ph. D., University of Cincinnati Medical Center.*

## Ohioans Elected to High Posts Of General Practitioners

Two Ohio physicians are in the top echelon of officers named at the recent annual assembly of the American Academy of General Practice in Las Vegas, Nev. Dr. Herbert W. Salter, Cleveland, was re-elected vice-president, and Dr. Lewis W. Cellio, Columbus, was re-elected vice-speaker of the Congress of Delegates.

Dr. James D. Murphy, Fort Worth, Texas, was installed as president. Dr. Albert E. Ritt, St. Paul, Minnesota, was named president-elect and will be installed as president at the 1963 session in Chicago during April.

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The Twelfth International Congress of Dermatology will be held in Washington, D. C., September 9 - 15.

# New Members . . .

The following are the names of the new members of The Ohio State Medical Association since May 31, 1962. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Franklin**

Kurt Lessy, Columbus

**Logan**

Erno Kooba, West Liberty

**Lucas**

Frederick I. Culler, Toledo
Jerome Gerber, Toledo
Robert J. Gosling, Toledo

**Mahoning**

J. James Anderson, Youngstown
George H. Dietz, Youngstown
Nicholas J. Garritano, Youngstown

**Richland**

Lewis L. Reese, Mansfield

**Stark**

Carmel J. Bozzi, Canton

**Summit**

Rocco M. Antenucci, Munroe Falls
Raymond S. Federman, Akron
Robert H. Finley, Akron
Fortune M. Odend'hal, Jr., Akron
Harry N. Pappas, Akron
William P. Sinclair, Akron

**Trumbull**

W. Clare Reesey, Jr. Girard

# Report from the Auxiliary . . .

## Summary of Activities for the Year Are Presented Before the House of Delegates at Monday Session

By MRS. LESTER W. SONTAG, Yellow Springs

MR. CHAIRMAN, Members of the House of Delegates, and Guests: For the Woman's Auxiliary to the Ohio State Medical Association, I wish to express our thanks for giving us this opportunity to present to you some of the highlights of our work this past year. Each President looks forward with appreciation to this occasion.

The Auxiliary is always pleased, at this time also to thank your Association for its generosity in help and time given to us by its officers and staff and for its annual gift of $1500 to our organization. As you know, this money is spent mainly for expert secretarial help, and we have found this of greatest assistance in getting material to our 60 counties, our 45 Board Members, and our 5358 Auxiliary members. This signal help is valued by all of us.

Two major areas of Auxiliary work have received extra and enthusiastic attention this year. First of all there has been an increase in legislative activity throughout the State; and secondly an increase in interest in Health Career projects and in AMEF.

In the matter of legislation: at the County level very few indeed were the reporting counties who had not had special legislation programs during the year. These programs ranged from studies conducted by the members themselves, to formal presentations on legislative bills and procedures given by lawyers, Congressmen or professors of political science. One large county conducted a seminar of four workshops designed to acquaint members with problems of medical legislation. A joint dinner workshop with the Medical Academy climaxed these sessions. Here an excellent question and answer period covered the King-Anderson, Kerr-Mills Bills. Legislative procedures were clarified. Experts in various areas gave specific and correct information to the group. As a result of these workshops, 25 members of this Auxiliary plan to meet each month with the Legislative Committee of the Academy to continue their studies.

### Operation Coffee Cup

At the County level, also, in response to Dr. Petznick's appeal some months ago, resolutions were sent opposing the King-Anderson Bill to Ohio Senators and Representatives. Individual Auxiliary members also have written letters to Congressmen and to editors expressing their views on current Medical legislation. "Operation Coffee Cup" has been widely and energetically used by our Counties.

At the state Auxiliary level, legislation activity has been accelerated. Our Board of Directors, at Dr. Petznick's request sent resolutions and letters to our Senators and all our Congressmen. The response has been good.



*Mrs. Lester W. Sontag, Yellow Springs, (right) then President gave the Report of the Woman's Auxiliary to the OSMA House of Delegates. Here she is being presented with Mrs. Edward Bauman, Warren, Incoming President.*

One month ago, under the expert direction of Mr. Charles Nelson, who worked with our National Area Legislation Chairman, Mrs. V. R. Frederick of Urbana, a State-wide, day-long Legislative Conference was held in Columbus. Auxiliary women from some 32 counties attended the meeting and listened with deepest attention to informative, thoughtful discussions of pending legislation and on legislative techniques. Your President, Dr. Petznick, spoke most

persuasively to the group, as indeed did Mr. George Saville, Mr. Hart Page, Mr. Charles Edgar of the Ohio State Medical Association staff, and Mrs. Frederick. An excellent speaker from the A. M. A. completed the panel. I speak for our Auxiliary when I thank you — especially Mr. Nelson — for the splendid opportunity you gave us to become better informed citizens.

### The Young Princes

A great Spanish medical historian and physician who considers medicine the *most noble of all the professions*, once called the students about to enter that field *The Young Princes*.

During 1961-62, for these the potential young princes (and indeed for other young people interested in paramedical careers), the Woman's Auxiliary has done, I believe, outstanding service.

Our donation to AMEF last year was, as you know, the largest by some $7000 of any of the 50 states. This year, although official comparisons may not be made until after our National Convention in June, I have every reason to believe we will again top all the states, this time by over $10,000. However, that may work out, we have, as of now, passed by several thousand dollars our last year's donation — our donation standing at $29,522.00 — an achievement of which all our members may be very proud indeed. [As of May 17, 1962, the donation had passed the amount of $30,000.00.] We give this money — which is raised, by the way, not just by asking our husbands for checks, but by selling Christmas cards, gift candles, AMEF playing cards, by giving benefit parties, and by working hard on many projects — as I say, we give this money with great satisfaction, knowing it will help meet, in a most effective way, needs of some of *the Young Princes*.

### Health Careers

Our efforts in this area have not been limited to raising money for AMEF. Appreciating the importance of attracting capable students to paramedical careers, especially nursing, County Auxiliaries offer Nurses' Scholarship and Nurses' Loans in generous fashion. Ranging from $50.00 to $500.00 to each accepted student, either as loan or outright gifts, these are important helps for many a worthy student. Amounts totalling thousands of dollars were given or loaned this year. In some counties — and at the State level this year — general paramedical (not just nurses) scholarships were given.

And this does not end our work with the high school potential in the medical or related careers areas.

Ohio Auxiliaries have sponsored, with greatest enthusiasm, Health Career Days throughout the year. In fact, Career Days have bloomed all over the state. One large Auxiliary working with other interested organizations planned for a day during which 1,500 high school students visited, in their area, Medical colleges, paramedical colleges, and laboratories. These students listened to professors, clinicians, laboratory experts, as they explained the requirements and discussed opportunities in medicine and allied fields. On a lesser scale, but of equal importance, smaller Auxiliaries performed similar services for interested students.

There are few more effective ways to insure good students selecting health careers for themselves than to let them know early in their high school years what splendid opportunities for service and for satisfaction medicine holds. That these Career Days take an enormous amount of organization and energy in their planning and executing goes, perhaps, without saying. Thanks to hundreds of Auxiliary women, thousands of Ohio high school students have been given good introductions into the challenge of medical careers.

### Recognized by Legislature

The Ohio State Legislature this year gave the Auxiliary recognition of this service to our State. In a Resolution introduced by Representative Walter Powell of Fairfield, the Auxiliary was commended highly for its activity in community welfare and particularly in the area of Health Career work. The Auxiliary was also given the honor of designating a time for a State-wide Health Careers Week each year. The Resolution was passed November 16, 1961. [Mrs. Herbert Warm of Butler County and the Butler County Auxiliary deserve credit for this Resolution as does Mr. Powell.]

It would be incorrect to give you the impression that Auxiliary activity has been limited to these two areas, important as they are. The Counties have done excellent work in Civil Defense, Rural and Mental Health, Safety, in general Community Service, and in helping our Senior Citizens.

In October 1961, the Auxiliary was given by the Civil Defense Department of Ohio its Distinguished Service Certificate for the most outstanding work done by any woman's organization in Ohio. This commended the work of our last year's President, Mrs. G. T. Harding III and her Civil Defense Chairman, Mrs. Hector McKnew. However, this year, with 35 counties giving active study to Civil Defense, we are continuing their fine efforts and making good progress.

### Safety

In the Safety area, new programs, particularly safety programs for children, were initiated and there was close cooperation with Ohio's safety organizations.

In service to our Communities, Auxiliary women give with extraordinary generosity of their abilities, energy and time. In one of our large counties, 1300 hours this year were given to one of the Auxiliary's projects, the transporting to Health Centers those who have no means of getting to them. In

# Social Highlight of the Annual Meeting




*The Grand Ballroom of the Neil House was the scene of the President's Ball, a gala affair.*

another county, hundreds of hours were given to registering school children for T. B. testing. Two weeks ago, I visited a county of 65 members. This group had helped process over 54,000 students for vaccination with Sabin oral vaccine. One of our largest counties, worked to help in a project which would vaccinate over a million men, women and children. The President of this Auxiliary helped organize teams to work in some 100 centers.

### Varied Programs

The evening would grow old if I were to tell you of all that Auxiliary women do for their communities.

Of great importance this year, was activity with Senior Citizens. One Auxiliary gave parties in its area for Senior Citizens at 18 homes for the aged. Another smaller Auxiliary annually sponsors a party honoring 200 Senior Citizens. All expenses, gifts, entertainment, refreshments are furnished by the Auxiliary.

Many other Auxiliaries also have regular schedules for the Senior Citizens. These women see to it that the older citizens will not be forgotten. Gifts, on birthdays and holidays, and parties are a part of their Auxiliary program. Our Auxiliary members care about our young people and help them; they also remember and care about those who are old.

This year of 1961-62, I designated last April, as the Year of the County. It was my wish to emphasize freshly my belief that in Auxiliary work our strength must come, in final analysis, from our County units. I asked each county to re-evaluate its potential and its aspiration and (with proper regard to National's requests) to work in those areas most suited to its local abilities and needs. The results do great credit to our Counties.

I've reported on a few specific areas to you. Note also that Auxiliary membership has reached a new high figure of 5361. Our counties are vigorous and dedicated; a clear focus on goals was set this year, and in the main, achieved.

I am intensely proud of Ohio's Auxiliary and very honored to have been, for one year, its President. The year of the County has shown me (what I'm sure I already knew) that our Auxiliaries, large or small, contribute with full dignity to the strength of our State and National organizations. I hope, as you evaluate our work, you will find that we also repay in some measure the confidence your organization has shown in us — that you will find we are truly an auxiliary to you.

Thank you and good night.

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### Chest Problems in Children

A postgraduate course in "Cardiopulmonary Problems in Children" will be presented at the Edgewater Beach Hotel, Chicago, July 23-27. The American College of Chest Physicians is sponsoring the program in cooperation with the American Academy of Pediatrics.

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Dr. Edward A. Gall, professor and director of the Department of Pathology, University of Cincinnati College of Medicine, was elected vice-president of the American Association of Pathologists and Bacteriologists at the recent meeting in Montreal, Canada, and was elected also to a three-year term on the executive council of the International Academy of Pathology.

# Woman's Auxiliary Annual Meeting . . .

## Report of Activities at Columbus Session, May 15 - 17. with Roster of New Officers

THE First Business Meeting of the 22nd Annual Convention of the Woman's Auxiliary to the Ohio State Medical Association was opened by the State President, Mrs. Lester W. Sontag.

The Guest Speaker was Dr. Thomas E. Rardin, Columbus, O., whose topic was "Teamwork in Medicine." His talk was both thought provoking and inspiring to the members of the Auxiliary, who are the "other half of the team."

Routine business matters were on the agenda, including election of the Delegates to the National Convention. The Ladies' Day Luncheon honored the county presidents, and Mrs. Sontag warmly thanked them for all the fine work they had carried out in their respective counties.

A delightful and entertaining Style Show was presented by an Auxiliary member, Mrs. N. M. Reiff, Washington Court House. Clothes for every occasion, selected from her Martha Washington Shop, were modeled by her staff.

At the afternoon meeting members were entertained by three skits. "It Can Happen in Any County" or "No Santa Claus," was presented by members of the Lucas County Auxiliary. Activities in a Smaller County was presented by three members of the Morrow County Auxiliary (their membership is only seven). Mrs. M. W. Sloan II, Montgomery County, ended by relating some of the activities and problems of the larger County Auxiliary.

In Memoriam Services were conducted by Mrs. Charles W. Pavey, Columbus. Each county president or representative, placed a white carnation on a white cross.

### National President Speaks

The High Point of Wednesday's meeting was an address given by Mrs. Harlan English, president of the Auxiliary to the American Medical Association. Her talk, titled "You and Your Auxiliary," pointed up the many ways each member can work for her own Auxiliary to promote better Public Relations, by taking part in community projects, to help create better Public Health, to keep informed and in turn inform others, particularly regarding legislation.

The Awards and Honors were presented to the County President or representative by the State Credits and Awards Chairman, Mrs. A. L. Kefauver.

Mrs. Hector C. McKnew, State Chairman for American Medical Education Foundation, also presented awards to counties contributing the most per capita, with the greatest percentage of increase in donations and others. By the end of Convention, Ohio had almost $30,000 contributed to A.M.E.F.

After the Doctors Day Luncheon, at which time the Franklin County Auxiliary Glee Club entertained, members had a "free" afternoon.

On Thursday, members were privileged to hear Dr. George J. Hamwi, the new President of the OSMA, speak. He thanked the women for their help in the past and assured them he will call upon them for future help as needed.

### Election of Officers

After the election of the Nominating Committee for 1962-63, reading and adopting of the several resolutions that had been presented on Tuesday morning, the 1961-62 Nominating Committee again presented the slate of Officers. The following were elected:

President-Elect, Mrs. Calvin Warner, Cincinnati
1st V-President, Mrs. James Wychgel, Shaker Hts.
2nd V-President, Mrs. A. S. Mack, Mt. Vernon
3rd V-President, Mrs. Robt. D. Hendrickson, Xenia
Recording Secretary, Mrs. Reuben Pliskin, Akron
Corresponding Sec'y., Mrs. R. J. Williams, Warren
Treasurer, Mrs. C. F. Goll, Steubenville

Directors-at-Large for Two Years are: Mrs. A. L. Kefauver, Columbus; Mrs. C. L. Blumstein, Lima; Mrs. Wallace Morton, Toledo.

Directors-at-Large for One Year are: Mrs. John B. Hazard, Gates Mills; Mrs. C. J. A. Paule, Toledo; Mrs. Frederic Rittinger, Cleveland Heights.

District Directors are: Mrs. M. W. Sloan II, 2nd District, Dayton; Mrs. George Lemon, 4th, Toledo; Mrs. John McDonough, 6th, Youngstown; Mrs. Hector C. McKnew, 8th, Newark; Mrs. Norris Lenahan, 10th, Columbus.

Mrs. Edward Bauman, Warren, was installed as president, having been elected president-elect in 1961, and the president's pin was presented to Mrs. Bauman by Mrs. Sontag, along with the Gavel. Past-President's pin was presented to Mrs. Sontag by Mrs. C. H. Bell. Officers were installed by Mrs. William Evans.

After a most interesting inaugural address by Mrs. Bauman, the Convention was closed. A May Day Brunch was held in the Sky Room, where members could meet the New President, her family and New Board of Directors.

The enjoyable smooth running Convention was due to the work and planning of the Convention Chairman, Mrs. Norris Lenahan, and her two Co-Chairmen, Mrs. A. F. Slininski and Mrs. H. J. Wynsen, with the co-operation of all the members of the Franklin County Auxiliary.

# OMI Applicants Total 26,775 . . .

## Campaign Attracts Attention of Senior Citizens: Promotion of Better Contracts Also Gains Momentum

OHIO Medical Indemnity's Senior Citizen Enrollment Campaign, April 30 through May 13, for persons 65 and over, resulted in 26,775 persons submitting applications for the new Senior Preferred Contract of O. M. I. The first campaign of this kind, two years ago, resulted in 75,000 applications.

OMI also conducted simultaneously an extensive advertising-educational campaign to advise those already enrolled in OMI under a Standard Contract about the better contracts of the company, namely, the Preferred and the Major contracts. The old Standard Contract is no longer being made available to new groups. Response to the ads approximated about 3,000 calls or inquiries from employers or employee representatives. Todate, about 400 groups have converted to one of the better contracts as a result of this advertising campaign.

### Purpose Educational

The purpose of the campaign was to point out to the public that the Standard Contract is of 1945 vintage and that suscribers would do well to check into, and enroll in, a better contract of OMI. This will be a continuing effort on the part of OMI. Since many of the groups enrolled are union-management negotiated groups discussions will be required about the possibilities of better coverage at the time of the reopening of contract negotiations.

### Coverage Reviewed

The new Senior Preferred Contract is essentially the same as the Special Preferred Contract which was offered in 1960. The expansion of radiotherapy to all conditions rather than being limited to neoplasms and neoplastic diseases is an added benefit.

The new contract indemnifies concurrent in-hospital medical services when certain skills possessed by a second physician are necessary in the treatment of a condition or conditions diagnosed as being unrelated to the surgical disease and when such services are not rendered by the attending or assistant surgeon and are not a part of the usual pre- and post-operative care.

There are no health statements, exclusions for pre-existing conditions, waiting periods or fine print to confuse subscribers.

In-hospital medical care is indemnified at the amount specified in the Preferred Contract and extends for a period of 30 days. If further hospitalization is necessary, 40 additional days medical coverage is provided. Per diem payments for psychoses and pulmonary tuberculosis are limited to 30 days. Surgery and anesthesia are indemnified at the Preferred Contract level.

This contract requires a statement of physician's charges which should be submitted with the claim application. Because of the level of benefits and the special status of this group of subscribers, information of physician's charges is an indispensable requirement of claim procedure.

Two new riders recently were adopted and issued by Ohio Medical Indemnity. One of these covers dependent children between the ages of 19 and 23. The other covers diagnostic X-ray, basal metabolism readings, electrocardiograms and electroencephalograms when rendered in a physician's office.

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### Academy of Medical History Elects Officers

The Ohio Academy of Medical History met on April 28 in Cleveland and elected the following officers for the year: Dr. George X. Schwemlein, Cincinnati, president; Dr. Perry R. Ayres, Columbus, Editor of *The Ohio State Medical Journal,* vice-president; Dr. Bruno Gebhard, 8911 Euclid Ave., Cleveland 6, re-elected secretary-treasurer.

The 1963 annual meeting will be held in Cincinnati.

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Robert G. Paterson, Ph. D., chief executive of the Ohio Tuberculosis and Health Association for 35 years before his retirement in 1952, was honored with the Harry L. Hopkins medal at the recent anniversary observance of the National Conference of Tuberculosis Workers in Miami Beach, Fla. Dr. Paterson has contributed many articles to *The Journal.*

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Ohio State University has been designated as one of 65 institutions in the United States to train students in clinical cytology under a new program set up by the U. S. Public Health Service.

# This Is Your Life . . .

## O. S. M. A. Past-President Carl A. Lincke Honored at Chamber of Commerce Program

DR. CARL A. LINCKE, Carrollton physician for the past 30 years and past-president of the Ohio State Medical Association, was honored by his home town and by representatives from the entire state at a surprise "This Is Your Life" program on May 16.

Among the 265 guests gathered to pay tribute to Dr. Lincke at the program presented by the Carrollton Chamber of Commerce, were several representatives of OSMA and their wives. These included: Dr. George W. Petznick, Shaker Heights, then President; Dr. Benjamin C. Diefenbach, Martins Ferry, Seventh District Councilor; Dr. Robert E. Tschantz, Canton, Sixth District Councilor; Mr. Charles S. Nelson, Columbus, Executive Secretary; and Mr. George S. Saville, Columbus, Assistant Executive Secretary.

During the program, which was narrated by Walter Flenniken, Chamber of Commerce Secretary, relatives and friends "behind the scenes" told about some of the doctor's experiences since his birth on Christmas Day, 1905, in Alliance, many being illustrated by photographs projected on a screen.

### Home Town Story

Dr. Lincke's life, as reviewed on that night, is best told by his hometown newspaper, *The Carrollton Free Press Standard.*

"Dr. Lincke was graduated from Alliance high school in 1923. He received his bachelor of arts degree from Ohio State University in 1927 and was graduated from the OSU Medical College in 1931. Dr. Lincke established his practice in Carrollton in July, 1932.

"He was instrumental in reorganizing the Carroll County Medical Society in 1936 and he was secretary-treasurer until being named president in 1941.

"In 1936, Dr. Lincke also was county health commissioner. He was elected in 1942 by the Ohio State Medical Assn. House of Delegates as Seventh District Councilor. In 1946 he was elected delegate from the OSMA to the American Medical Association House of Delegates and is still serving the state in that capacity, being one of the veteran members of the AMA House.

"Dr. Lincke was elected president of the OSMA in 1949. He was one of the organizers of Ohio Medical Indemnity, Inc., Ohio's Blue Shield medical plan which is sponsored by OSMA, and he served on the board of directors and executive committee for many years.

"Dr. Lincke was president of Carrollton Rotary Club in 1944 and served as district governor of Rotary International in 1957-58. He and his family have attended Rotary conventions in Mexico and Switzerland.

"In addition, Dr. Lincke is a member of Alliance Elks Lodge, Carroll Masonic Lodge, Tadmor Shrine and is now president of the Tuscarawas Shrine Club.

"He became a director of The Cummings Bank Co. of Carrollton in 1945 and was elected president of the board in 1960. Dr. Lincke also has served on the local board of public affairs and the planning commission.

"An avid hunter, several stories were told, illustrated with photographs of some of Dr. Lincke's hunting expeditions, especially in the Bowerston, Sherodsville and Leesville area, and other points in Ohio.

"Dr. Lincke's wife, Marie, and their daughter, Mrs. Carl (Ann) Saltsman, of Canton, were present for the affair. However, their son, Carl Edward, who will complete work in hospital administration at the University of Minnesota in June, was unable to attend."

In addition to Dr. Lincke's activities in the AMA which were reported in the *Free Press Standard,* he was a two-term member of the AMA Council on Scientific Assembly and served for two years as its chairman. He only recently retired from that Council in compliance with the rule that no one can serve more than two terms.

### Life Portrayed

Four phases of Dr. Lincke's life were portrayed by boys in costume. Dr. Lincke viewed the parts of his life as a news boy, a cornet player, a railroad employee, and a young doctor, acted out before him by local admirers in costume.

In attendance were also some 20 physicians representing the Carroll County Medical Society, many friends and relatives, and even a former classmate who traveled from Atlanta, Georgia, to honor Dr. Lincke.

The celebration came as a complete surprise to Dr. Lincke but he added greatly to the entertainment by calling frequently on his store of dry wit and humor to reply to the introductions of the "surprise" guests.

Some of the many pictures taken of the event appear on the next page.

# High Points Recalled in Career of Community Doctor



*Still showing the surprise of it all, Dr. Lincke holds the "This Is Your Life" book, a gift of the Chamber of Commerce and permanent testimonal of the occasion.*



*Mrs. Lincke is elated as OSMA President George W. Petznick (right) friend and colleague of long standing, arrives from Cleveland to greet Past-President Lincke.*



*From Columbus came these friends and fellow workers of long standing to play leading roles in the program. Left to right are Charles S. Nelson, Executive Secretary of OSMA; Mrs. Nelson; Mrs. Saville, and George H. Saville, OSMA Director of Public Relations. Mrs. Lincke is seated at right.*

# Speaking Out . . .

## Ohio Doctors Oppose King-Anderson Bill in Speeches and Newspaper Ads

THE activities of the physicians of Ohio in their opposition to the Kennedy sponsored King-Anderson Bill (H. R. 4222) reached a fever pitch in May. Doctors have been speaking at meetings of all types, telling the reasons why this controversial piece of legislation should not be enacted. Paid advertisements, sponsored by county medical societies pointing up the views of opponents, have been published in many newspapers. Reported below are some of the many activities sponsored by and participated in by Ohio physicians.

Dr. Paul MacCarter, Chairman of the Ross County Medical Society's Committee on Community Health, discussed the King-Anderson Medical Bill at the May 21 Chillicothe Rotary Club luncheon.

On May 24, a panel discussion on the controversial H. R. 4222 was held at the Dover Public Library . . . open to the public. Sponsored by the Tuscarawas County Medical Auxiliary, the panel consisted of Dr. Robert Rinderknecht of Dover and Dr. Robert Tschantz, Dr. William White and Dr. Maurice Lieber, all of Canton.

Earlier in May, Dr. H. F. Banfield of East Liverpool, president of the Columbiana County Medical Society, sharply criticized the King Bill before the Chester Kiwanis Club.

Dr. William Epps, Massillon, discussed the provisions of this proposed legislation before both the Beach City Grange and the Crystal Springs Grange in May.

Dr. Louis Chandler Roettig discussed the Bill before the Columbus Downtown Kiwanis Club in early May.

Dr. Jack Schreiber, Canfield, was a very busy man in May. He engaged in a debate with E. J. Nestigen, undersecretary of the Dept. of HEW on a radio program, "The Leading Question," on May 11. This debate was recorded at the Capitol in Washington, D. C., and rebroadcast.

Following that debate, Dr. Schreiber appeared as the featured speaker at the May 14 meeting of the Salem Area Chamber of Commerce, again speaking against the King-Anderson Bill.

On May 17, Dr. Schreiber again took the platform to debate the H. R. 4222 issue. This time his opponent was Irvin Ryan, community services director for the United Steelworkers of America.

Dr. Henry L. Shorr, Youngstown, discussed "Socialized Medicine" at the May meeting of the Coitsville Township Farm Bureau Council.

Dr. Walter Reiling, representing the Montgomery County Medical Society, debated the King-Anderson Bill before the Dayton Community Welfare Council.

### Here's Status of H. R. 4222 As of Press Time

As this issue of *The Journal* went to press on June 20, H. R. 4222, the King-Anderson Bill to establish a compulsory governmental health insurance plan under Social Security for persons 65 years of age or over, was still bottled up in the U. S. House of Representatives Ways and Means Committee. Closed conferences on the measure have been held spasmodically by the committee. When a vote will be taken is uncertain.

There have been reports that the Kennedy Administration is willing to settle for a compromise proposal but will insist that the financing be done under Social Security. Concurrently there have been reports that the majority of the members of the Ways and Means Committee still are against any bill which links the medical care plan to Social Security.

Most reliable reporters on the Washington scene believe the bill is dead so far as this session of Congress is concerned. On the other hand, the AMA and other groups are continuing to encourage citizens to contact their congressmen in opposition to H. R. 4222, believing the fight will continue right down to the actual hour of adjournment of the 87th Congress.

H. R. 4222 was treated to a frank and probing discussion by a panel of physicians before the Steubenville Rotary Club. Participating in that panel were Dr. Walter A. Cunningham, Dr. Stanley L. Burkhardt, Dr. Gary Eicher and Dr. Paul Ruksha, all members of the Jefferson County Medical Society.

The House of Delegates of the Ohio State Medi-

cal Association, at the closing session of its 1962 Annual Meeting, unanimously adopted a resolution submitted by Mahoning County, reaffirming the association's "opposition to any legislation of the King-Anderson type."

On May 27, Dr. David Greegor, representing the Academy of Medicine of Columbus and Franklin County, debated the medicare issue on "Columbus Town Meeting," a joint radio-television program in Columbus.

In addition to the speakers who have been fighting to defeat the King-Anderson Bill, many county and local medical societies have placed paid advertisements in newspapers across the state, pointing up medicine's reasons for opposing this Bill and asking that letters be written to Senators and Congressmen. Also, innumerable "letters to the editor" have been written by physicians and their wives opposing the enactment of H. R. 4222.

As of May 30, the OSMA headquarters office in Columbus had received ads placed by the following county and local societies: Holmes County Medical Society, the Academy of Medicine of Cincinnati and the Campbell-Kenton (Kentucky) Medical Society, the Marion Academy of Medicine, the Fairfield County Medical Society, the Miami County Medical Society, the Huron County Medical Society, the Coshocton County Medical Society, the Delaware County Medical Society, the Mahoning County Medical Society, and the Scioto County Medical Society.

# Do You Know? . . .

Dr. Donald I. Minnig, Akron, is the newly elected president of the Ohio Orthopedic Society. Dr. Minnig is a former president of the Summit County Medical Society.

* * *

Dr. Francis G. Kravec, Youngstown, has been elected president of the Ohio Chapter of the American College of Chest Physicians. Dr. Kravec is medical director of the Columbiana County Tuberculosis Clinic.

* * *

Dr. Laurence M. Weinberger, Akron, has been elected secretary of the Ohio State Society of Neurosurgery.

* * *

Dr. Middleton H. Lambright has been named president-elect of the medical staff of Metropolitan General Hospital, Cleveland. Other officers elected are: Dr. Joseph B. Stocklen, president, and Dr. Eli Gold, secretary-treasurer. Dr. Lambright was also recently elected vice-president of the Cleveland Academy of Medicine.

* * *

Dr. Stanley E. Dorst, retiring Dean of the College of Medicine at the University of Cincinnati, received a Doctor of Humane Letters degree at the school's commencement exercises on June 10.

* * *

Dr. Othilda Krug, director of the Child Guidance Home and professor of psychiatry at the University of Cincinnati College of Medicine, has been elected to the governing council of the American Psychiatric Association. This is the first time since the APA was founded that a woman psychiatrist has been chosen for the council.

* * *

Dr. Joseph M. Foley, director of the Division of Neurology at University Hospitals, Cleveland, received one of seven honorary degrees given June 13 at the 116th commencement of the College of Holy Cross in Worcester, Massachusetts.

* * *

Dr. Josef Warkany, professor of research pediatrics at the University of Cincinnati College of Medicine, has won the 1962 Sigma Xi award for distinguished research.

* * *

C. H. John Padrutt, executive director of the Anti-Tuberculosis League of Summit County, is the new president of the Ohio Public Health Association.

* * *

Dr. Irvine H. Page, director of research at the Cleveland Clinic, recently received the John Phillips Memorial Award, one of the highest awards of the American College of Physicians.

* * *

Dr. Harvey C. Knowles, Jr., Cincinnati, a research scientist specializing in diabetes and related carbohydrate and mineral disorders, has received a research career award from the U. S. National Institutes of Health. Dr. Knowles is a professor of medicine at the University of Cincinnati College of Medicine.

* * *

Dr. R. W. Weiser, of Jewett, was one of a group of American doctors who attended the International Congress on Hormonal Steroids in Milan, Italy.

* * *

Dr. Clark T. Randt, Shaker Heights, has been appointed professor of neurology at New York University School of Medicine and director of the university's third neurology division at Bellevue Hospital Center.

* * *

Dr. Harry Goldblatt, Cleveland, has been awarded a $1,065,000 research grant by the National Heart Institute of the U. S. Public Health Service.

## Licensed Through Endorsement By State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

Michael Meftah, Columbus, University of Tehran; Oscar Chichioco Reyes, Cleveland, University of Santo Tomas; Harold Norman Richardson, Bexley, University of Rochester; Leonard Alfred Scharf, Cleveland, University of Michigan; Lester E. Wall, Jr., Marion, St. Louis University; Ava June Wolfe, Cleveland, Baylor University.

* * *

Nancy Bright Austin, Akron, Woman's Medical College of Pennsylvania; Herbert M. Awender, Barberton, University of Vienna; Jerome Bernstein, Cincinnati, University of Bologna; Franklin D. Bressler, Columbus, Indiana University; Gerold Eugen Bruggar, Dayton, University of Teubingen;

Albert E. Chalom, Youngstown, Ein Shams University, Egypt; Edward Howard Chester, Cleveland, New York University; Gary Nelson Cohen, Cincinnati, University of Buffalo; Eugene Joseph Coyle, University of Edinburgh, Scotland; Earl C. Davis, Jr., Columbus, University of Virginia; Harold Alvin Decker, Columbus, University of Utah; George Daniel Denton, Athens, Queen's University, Canada;

Eugene B. Elam, Cincinnati, Medical College of South Carolina; Richard Gilbert Farmer, Cleveland, University of Maryland; Charles Henry Fortson, Dayton, Meharry Medical School; Ferdinand E. Fournier, University of Budapest; Smith Hyson Gibson, Cincinnati, University of Louisville; Charles A. Gilbert, Cincinnati, University of Illinois; Doris Goodman, Cleveland, Woman's Medical College of Pennsylvania;

Charles Dana Hershey, University of Michigan; William George Heusel, Springfield, University of Nebraska; Rodrick J. Hinshaw, Greenville, Vanderbilt University; Karol Alexander Hoffman, Youngstown, University of Vienna; William Thompson Holland, Jr., Cleveland, Jefferson Medical College; John Homi, Cleveland, University of London;

Archbold Marion Jones, Jr., Marietta, Jefferson Medical College; Joseph Kavtschitsch, University of Munich; Muryl Loye Laman, Cleveland, University of Kansas; Nicandro Villapando Leano, Vermilion, University of Santo Tomas; Hans Leen, Cleveland, National Taiwan University; Royston Cornwell Lewis, Cleveland, University of London; Stephen Julian Lewis, Cincinnati, University of Pennsylvania; John A. Logan III, Toledo, Vanderbilt University;

John C. MacLennan, Oak Hill, McGill University; Michael Anthony Maddalena, Cleveland, University of Tennessee; Richard T. Marnell, Cincinnati, State University of New York; Richard Charles Miller, Cleveland, Harvard Medical School; Dallas Ott Minchin, Youngstown, Temple University; Roland Wallace Moskowitz, Cleveland, Temple University; Albert Mowlem, Cleveland, Yale University;

Miguel Gomez Nieto, Dayton, National University of Mexico; Fortune Odend'hal, Jr., Akron, University of Maryland; Charalambos N. Papacharalambous, Akron, University of Athens; Harry N. Papas, Akron, University of Athens, Greece; Jesus Fabros Pascua, Columbus, University of Santo Tomas; Forrest E. Richert, Toledo, University of Kansas; Melvin Stanley Rosenthal, Cleveland, George Washington University; Miriam H. Bernstein Rosenthal, Cleveland, George Washington University;

Robert Basil Scheidt, Van Wert, Northwestern University; O. David Solomon, Cleveland, University of Pittsburgh; Mervyn Moses Davis Sopher, Cleveland, University of Calcutta, India; Jose Duque, Soriano, Cleveland, University of St. Tomas; Konstantin Sprosts, Gallipolis, University of Latvia; Lukacs Szabo, Columbus, University of Budapest;

Agustin Torres, National University of Mexico; Jordan Herman Trafimow, Cleveland, University of Illinois; Eugene Tschekunow, Hamilton, University of Munich; Stanley van den Noort, Cleveland, Harvard Medical School; William Stratin Vaun, Cleveland, University of Pittsburgh;

Arville Vance Wheeler, Cincinnati, Vanderbilt University; Patrick C. Williams, Jr., Medical College of Virginia; Alan Verl Yoho, Kent, Medical College of Virginia; John William Zerkowski, Georgetown University.

* * *

By Examination: Karamfil S. Staneff, Columbus, University of Heidelbert; Hans Gustav Bergeest, Oxford, University of Marburg.

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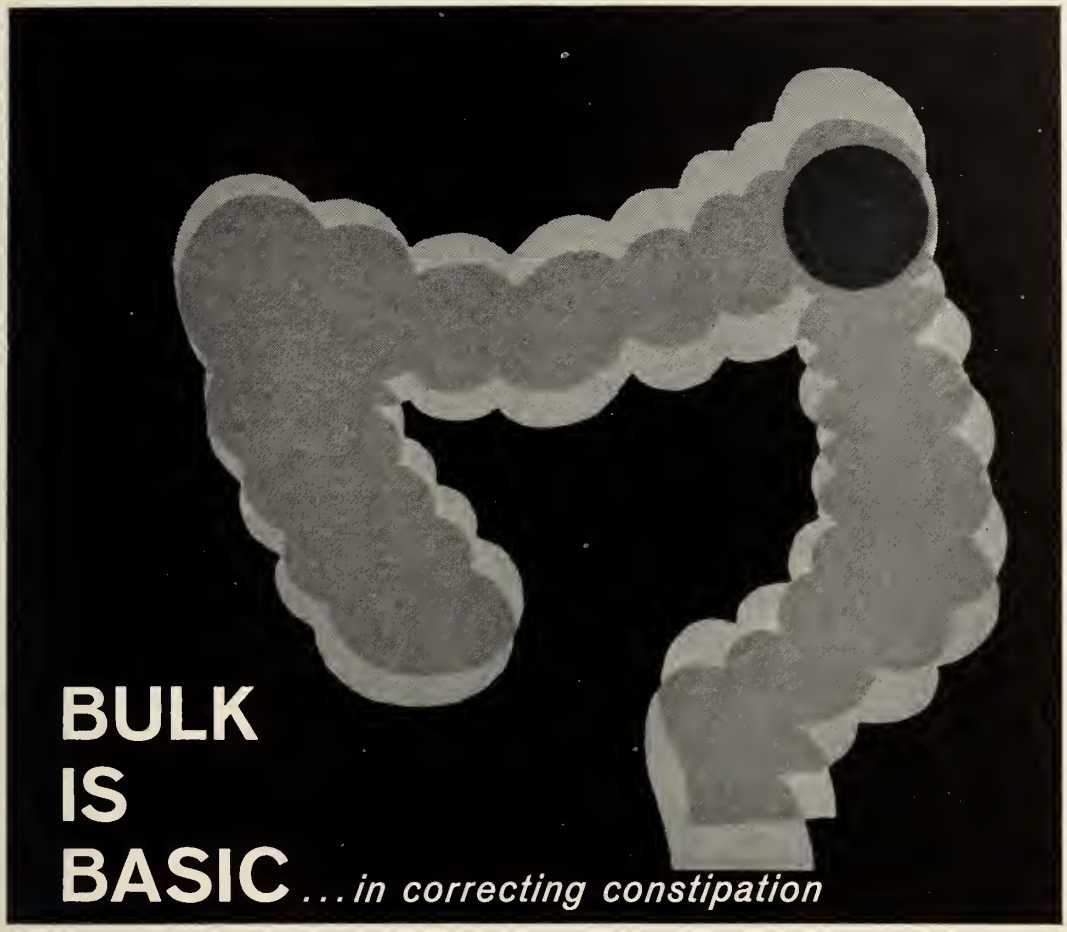
## Grant Furthers Angiography Studies at Cincinnati

The University of Cincinnati College of Medicine has been given a National Institutes of Health grant for continuation of its studies in angiography. The award amounts to $26,251 for the program's first year and $122,403 for four additional years.

Principal investigators will be Dr. Charles D. Aring, professor and director of the Department of Neurology; Dr. Samuel A. Trufant, associate dean and associate professor of neurology; Dr. Charles P. Olinger, neurology; and Dr. Luis L. Gonzalez, surgery. Clinical work will be done principally at Cincinnati General Hospital and the Cincinnati Veterans Administration Hospital.

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Dr. George S. Shields is continuing his studies on the relationship between copper and connective tissue production at the University of Cincinnati under a $14,975 grant from the National Institutes of Health.




# METAMUCIL®

BRAND OF PSYLLIUM HYDROPHILIC MUCILLOID

## STRENGTHENS THE COLONIC REFLEX

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The stimulus which initiates the defecatory reflex is the fecal mass in the lower sigmoid colon and rectum. Metamucil provides that mass as a bland, nonirritating, easily compressed bulk, similar in consistency to the normal protective mucus of the colon. Taken regularly, Metamucil tends to correct the insensitive reflex of a bowel abused by laxatives and to restore the natural responsiveness to the urge to stool.

Metamucil is available as Metamucil powder in 4, 8 and 16-oz. containers and as lemon-flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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*Research in the Service of Medicine*

# Workmen's Compensation . . .

## Fourth of a Series of Articles on the Ohio Program Shows Physicians How To Obtain Prompt Payment

THIS is the fourth in a series of articles being published in *The Journal* pertaining to the administration of the Ohio Workmen's Compensation Law, especially about procedures of special interest to physicians. Clip these articles for ready reference. Additional articles will be published. Watch for them. This month's article summarizes some of the general rules relating to medical services.

### Treatment For Unrelated Conditions

The Bureau of Workmen's Compensation will pay for treatment of a condition which is unrelated to injury as long as it is clearly evident that the unrelated condition is aggravating the industrial injury, preventing healing, or prolonging the disability. As soon as the unrelated condition is no longer affecting the industrial injury the responsibility of the Bureau of Workmen's Compensation for its treatment ceases and payment for any subsequent treatment that may be given will be claimant's own responsibility.

### Signature of Physician Is Required

Medical reports and fee bills shall be signed in the handwriting of the physician rendering the services with the name in legible printing or typing beneath the signature. State professional license number should be placed on all forms submitted to assist the Bureau in processing the form.

### Treatment By Two Doctors at Same Time

Except in cases where a consultant, anesthetist or assistant is required, or the necessity for treatment by a specialist is clearly shown, fees are not approved for treatment by more than one physician for the same condition over the same period of time.

### Change of Doctors Must Be Authorized

A claimant is not permitted to change from one physician to another without submitting the reasons for such change in writing and obtaining the written consent of the Bureau for the transfer. A copy of claimant's reasons for such change will be furnished the previous physician on request. This rule does not apply, however, to cases referred to a specialist by the attending physician or to transfers made immediately following emergency or first-aid treatment.

**Want A Speaker on Subject of Workmen's Compensation?**

The Bureau of Workmen's Compensation and the Industrial Commission of Ohio will be happy to provide a speaker on Workmen's Compensation, with special emphasis on fee bills, claims procedure and related subjects. Requests should be directed to: Mr. George H. Thompson, Chief Deputy Administrator, Claims Section, Bureau of Workmen's Compensation, Columbus 15, Ohio.

### Time Limit For Payment of Fees

Fee bills for medical, hospital and nursing services and for medicines and appliances, are forever barred from payment unless they are filed within two years from the time such services were supplied, or within six months from the time the Bureau has assumed jurisdiction in a contested or reopened claim.

Claims for injuries must be filed within two years from the date of injury or be forever barred.

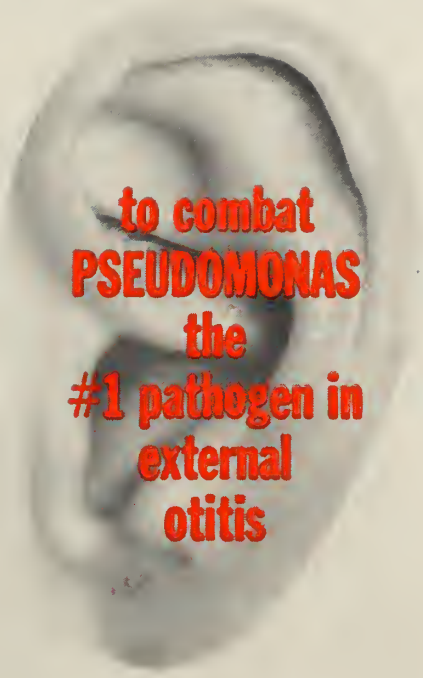
### Apportionment of Flat Fee

When one physician performs any service for which there is an established flat fee and another physician renders the after-care, or any portion of it, a fee will be approved for each physician commensurate with the services rendered, but the total of fees approved will not exceed the flat fee. When cases are referred to another physician for after-care, it is the responsibility of the referring physician to notify the Bureau immediately.

### Flat Fee In Fatal Injuries

Flat fees do not apply to cases which terminate fatally within a short period of time after injury.

*(Continued on Page 840)*




# 'CORTISPORIN'®

## OTIC DROPS (sterile) brand

## the #1 therapy for inflamed, infected ears

**Because it provides Polymyxin B** for the eradication of Pseudomonas, the prime cause of external otitis, 'Cortisporin' is the logical choice of treatment for inflamed, infected ears. Polymyxin B is the antibiotic specific for *Pseudomonas aeruginosa* infections, and is, for this pathogen, the standard of effectiveness against which other antibacterials are measured.

- Anti-inflammatory
- Antipruritic
- Antibacterial



Each cc. contains:

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| 'Aerosporin'® brand Polymyxin B sulfate | 10,000 units |
| Neomycin Sulfate (Equivalent to 3.5 mg. Neomycin Base) | 5 mg. |
| Hydrocortisone | 10 mg. (1%) |

*Bottles of 5 cc. with sterile dropper.*

Literature available on request.

**BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.**

(Contd. from Page 838)

The fees approved in such cases are based on the services rendered.

### Fee Where Consultant Continues Treatment

In cases where the consultant continues to treat the claimant, a fee for first treatment will be paid to the consultant rather than a consultant's fee unless it is affirmatively shown that the referral by the attending physician for treatment by the consultant followed the receipt and evaluation of the consultant's report. The fee for first treatment is not paid in addition to a specified flat fee.

### Must Show Need For Daily Dressings

Fees for daily dressings are not approved unless the proof on file shows the necessity for the same.

### Where Unusual Care Is Required

In cases requiring unusual treatment not contemplated under ordinary circumstances, the physician may receive additional compensation at the discretion of the Bureau. A detailed explanation should be submitted with a fully itemized fee bill.

### Extra Allowance In Unusual Cases

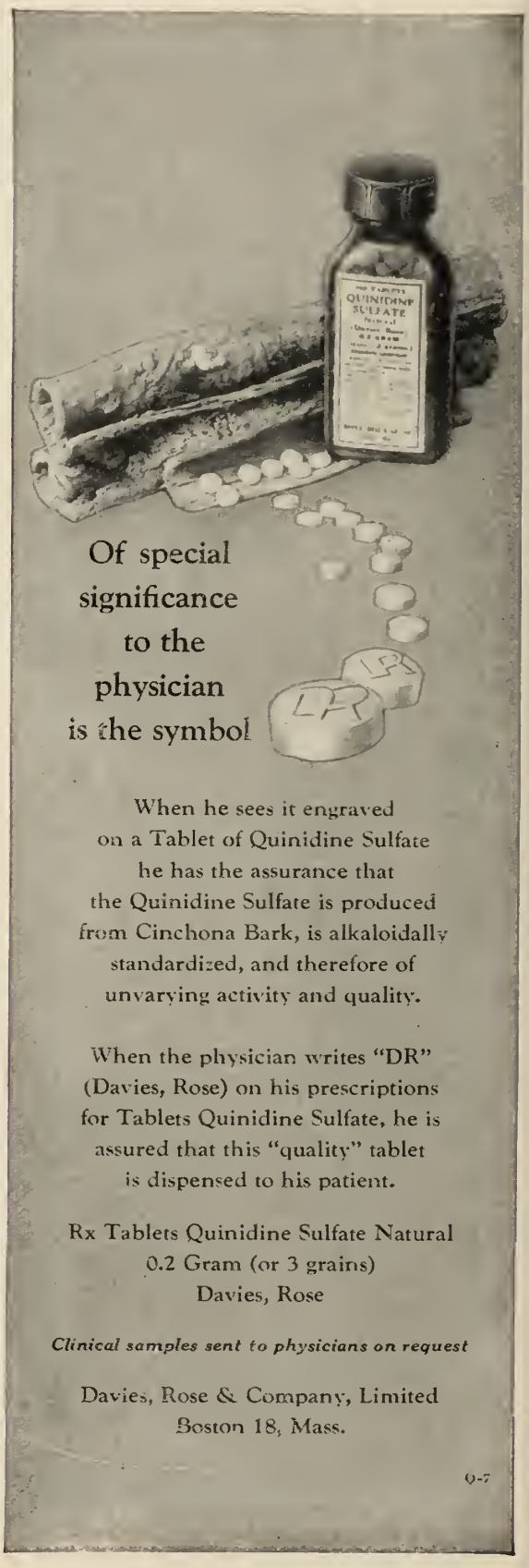
The fees for treatment at the office and home include ordinary medication and dressings. Additional fees for dressing materials and drugs are not approved except in fully explained cases wherein an extraordinary amount of such material or drugs is used or expensive drugs are administered. In such cases, the materials or drugs are paid for at cost to the physician.

### Authorization Need For Physiotherapy

Fees for physiotherapy will not be approved for more than ten treatments unless authorized. The nature of the disability must clearly indicate the necessity for such treatment. Additional fees for physiotherapy in cases covered by a flat fee are not approved without specific authorization. The term "physiotherapy" includes such treatment as manipulation, massage and all types of thermal, electrical and hydrotherapy.

### Authority For Surgery Except In Emergency

Except in emergencies or where the condition of the patient may be endangered by delay, written authority from the Bureau must be obtained in advance for all surgical procedures. Failure to comply with this rule will result in disapproval of the surgeon's fee.



# Two-Way Radio for Physicians . . .

## Plan for Members of Ohio State Medical Association Who May Be Interested in Project Is Summarized

RECENTLY the Ohio State Medical Association was requested to set up the framework whereby Ohio physicians could participate in a uniform and correlated two-way radio communications program in the state, serving physicians, hospitals and those providing auxiliary medical services.

An investigation of this suggestion by certain members of the Association revealed:

(1) The Federal Government has not set aside exclusive radio frequency bands for physicians and hospitals but they are eligible under Rules and Regulations of the Federal Communications Commission known as Part 10, Public Safety and Radio Services, Subpart J relating to special Emergency Radio Service; (2) the Ohio State Medical Association cannot obtain a license for its members as a group — license must be obtained by any interested physician on an individual basis; (3) certain frequencies or bands of frequency are available for assignment to physicians and hospitals in the Special Emergency Radio Service (Section 10.462 of the regulations).

### Must File as Individuals

Therefore, physicians who may be interested in securing a license to operate a two-way radio hook-up with their own office or hospital should file application as individuals with the Federal Communications Commission, Washington 25, D. C. Copy of application blank and instructions for filing may be obtained from that office. A hospital interested should do likewise.

**It is recommended that physicians and hospitals who may apply, ask to be assigned to Frequency 155.280 Mc. Uniformity would be achieved if all Ohio physicians and hospitals would ask for and be assigned this frequency. The Commission should be asked to assign some adjacent channel in event 155.280 is unavailable. In other words, Ohio physicians and hospitals should aim to obtain assignment in the same channel or in the same group of adjacent channels.**

### Some Pertinent Questions

The Ohio State Medical Association was assisted in investigating this matter by Mr. Ted Fox, zone sales manager for the Motorola Communications and Electronics, Inc., with offices at 1820 Northwest Blvd., Columbus. The company also maintains offices in Cincinnati, Cleveland, Dayton and Toledo.

**Physicians who may be interested in this project and working out some uniformity, if possible under the Federal regulations, should communicate with Dr. George N. Spears, 2213 S. Ninth Street, Ironton, Ohio.**

To give physicians pertinent information on this subject, Mr. Fox, at the request of the Ohio State Medical Association, prepared the following questions and answers:

Q. Who can have two-way radio equipment?

A. To use FM two-way radio equipment a physician must have an FCC radio system license. Physicians are eligible for an FCC radio license under the special emergency category. Look under Part 10.453 of the FCC rules and regulations.

Q. What radio channels are available to physicians?

A. The FCC has set aside a certain number of channels for the special emergency service. Physicians are eligible to hold a license to operate on a certain frequency in this special emergency category.

Q. Is it difficult for a physician to obtain an FCC license?

A. On the average it takes about 60 days to obtain an FCC license for a two-way radio system. There is no license fee as such at the present time. Your supplier will be glad to assist you in obtaining your FCC license.

Q. Will I be assigned my own exclusive radio channel?

A. No. All radio channels in the special emergency service are assigned on a shared basis. You must expect to share the use of your channel with other physicians, veterinarians, hospitals, ambulance

operators, and other persons eligible in the special emergency category.

Q. What radio equipment is required to establish a two-way radio system?

A. The normal FM two-way radio system consists of a base station tower and antenna usually located at the physician's office or home and a mobile radio unit installed in the physician's vehicle.

Q. How far can I talk with a two-way radio system?

A. Most two-way radio systems have a range from 10 to 35 miles radius from the base station. This is measured in air miles or as the crow flies. The average two-way radio system has a range approximately 20 miles from the base station.

Q. How much does a two-way radio system cost?

A. The cost of a two-way radio system varies with the range required, the type of terrain in which the system is to operate, the ground elevation of the base station and the mobile units, and the type of mobile unit desired. Base station costs vary usually from between $1200 to $2500 and mobile units vary from approximately $500 to $1000. Installation on a base station usually runs between $75 and $125 and between $30 and $35 per mobile unit.

Q. Who will install the radio equipment?

A. Anybody who installs two-way radio equipment and maintains that equipment must have an FCC second class or first class commercial license. The equipment supplier can usually provide the men who are qualified to install the radio equipment.

Q. How much maintenance is required on FM two-way radio?

A. The FCC has established certain minimum maintenance requirements for FM two-way radio equipment. Any person maintaining FM equipment must be technically qualified and must hold an FCC second class or first class commercial license. Regular maintenance is available from the service stations of your radio equipment supplier.

Q. Where do I get further information of the exact costs for a radio system for my use?

A. See your nearest radio communications representative. Motorola Communications & Electronics, Inc., has five offices in Ohio. Contact one of these locations, or others, for specific information on FM two-way radio equipment.

# Coming Meetings . . .

American College of Surgeons, Ohio Chapter, Pick-Ohio Hotel, Youngstown, September 14-15.

American College of Surgeons, Clinical Congress, Atlantic City, October 15-19.

American Medical Association, Clinical Meeting, Los Angeles, November 25-28.


## Changed Your Address? If So, Send the New One to Us Promptly

If you have moved, you will want *The Journal* and other OSMA mail mailed to your new address. Please use the coupon below to give us this information and mail the coupon to the Ohio State Medical Association, 79 E. State St., Columbus 15, Ohio, immediately as it takes several weeks to get our mailing list adjusted.

NAME (print) .....

OFFICE ADDRESS .....
Street City Zone

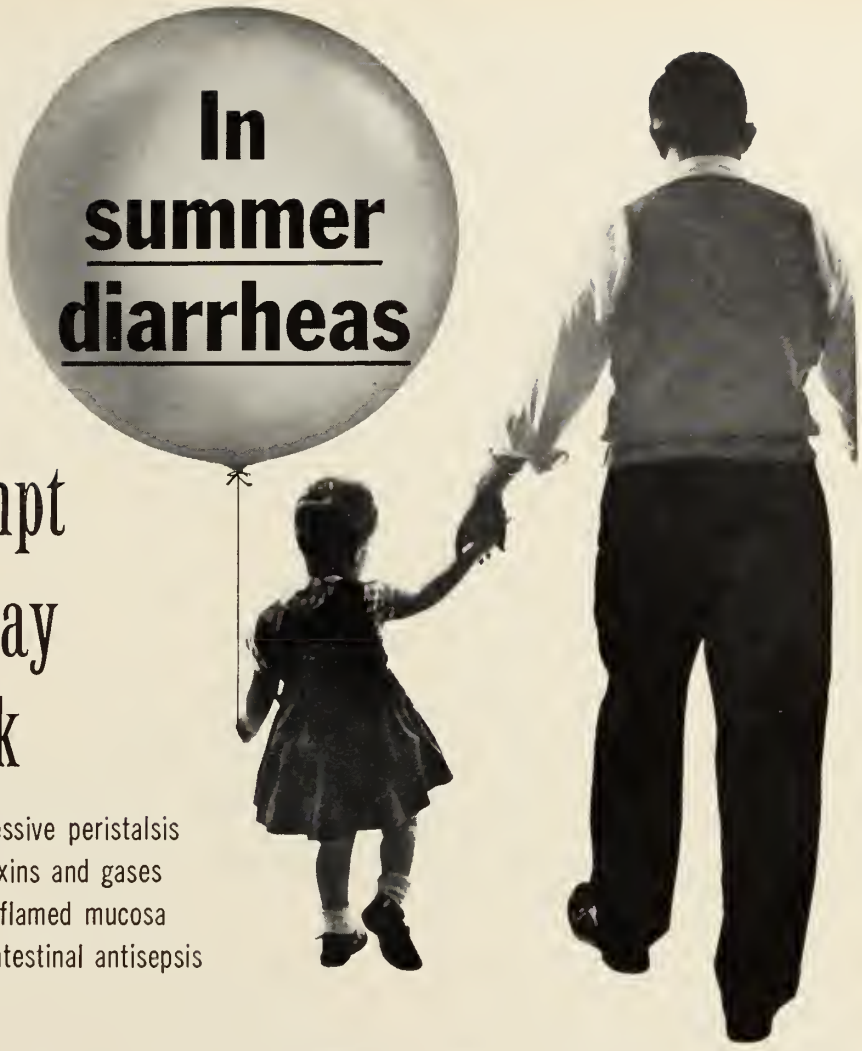
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SEND MAIL TO Office address ☐ Home address ☐

# In summer diarrheas



## prompt 4 way check

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
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EFFECTIVE ANTIDIARRHEAL

**FORMULA:** *Each 15 ml. (tablespoon) contains:*

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| Sulfaguanidine U.S.P. | 2 Gm. |
| Pectin N.F. | 225 mg. |
| Kaolin | 3 Gm. |
| Opium tincture U.S.P. | 0.08 ml. |

(equivalent to 2 ml. paregoric)

Warning: May be habit forming.

**DOSAGE:** **Adults**—Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

**Children**—½ teaspoon (= 2.5 ml.) per 15 pounds of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

**SUPPLIED:** *Bottles of 1 pint (raspberry flavor, pink color)*
*Exempt Narcotic. Available on Prescription Only.*

Winthrop LABORATORIES
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# Ohio's Health Care Plan for Aged . . .

## State Has Excellent Aid Program and Is Getting Assistance From U. S. Under the Kerr-Mills Law

HERE is the text of a statement issued on June 13 by Dr. Geo. J. Hamwi, President of the Ohio State Medical Association to all Ohio newspapers and radio and TV stations for the purpose of informing the people of Ohio of the program offered by the state to help persons 65 and over with their medical and other needs and to clarify misunderstandings and misconceptions about the Ohio Aid for the Aged program.

* * *

"Ohioans 65 or over who need assistance in meeting their medical, hospital, nursing and other health needs can obtain, and are receiving, such help under the regular health care program of the Ohio Division of Aid for the Aged which has been expanded with financial help from the State Legislature to meet such contingencies.

### Ohio Does Have Program

"There has been a lot of loose talk to the effect that Ohio has no program to help its needy aged citizens with their health problems," said Dr. Hamwi. "It is time to let the people know that Ohio does have a program which appears to be meeting current needs."

Dr. Hamwi pointed out that he felt it advisable to cite some facts regarding the situation in Ohio on health care for the aged inasmuch as some who have been arguing in favor of the King-Anderson measure pending in Congress have either been uninformed or misinformed about Ohio's participation in the Kerr-Mills program enacted by Congress in 1960.

"Public reference to Ohio's 'medical only' program for aged citizens," he said, "was made as long ago as June 1, 1961, when Mrs. Mary Gorman, state welfare director, in testimony before the State Senate Finance Committee referred to 'the decision of the House of Representatives in which, incidentally I concur, to embark upon a medical only program in lieu of enabling legislation for participation in the medical program provided for by the Kerr-Mills Act.'

"Mrs. Gorman at that time also made this statement to the press: 'The point is that we have a medical care program and some states don't.'

"Speaker of the House Roger Cloud in a public statement at about that time, relating why he felt Ohio did not need enabling legislation said: 'Ohio now has a workable agreement with the Federal Government, and I'm rather persuaded it would not be to our advantage to disturb it.' Mr. Cloud referred to the fact that Ohio had more liberal provisions for Aid for the Aged benefits and over-65 medical care than many states did at the time the Kerr-Mills legislation was passed. Ohio sets no income limit for eligibility but provides assistance on the basis of need.

"In a recent bulletin of the U. S. Department of Health, Education and Welfare there appeared a list of certain states which have enacted medical assistance for the aged for the first time. Commenting on this, the bulletin said: 'In addition three states — Indiana, North Carolina and Ohio — expanded their old age assistance programs to include persons in need of medical care but not in need of money payments.' It is interesting to note, also, that the American Medical Association lists Ohio as a state where legislation was not enacted but where the existing old age assistance program was expanded to meet the needs which the Kerr portion of the Kerr-Mills Law is designed to meet.

### Program Twice Expanded

"Ohio has had an active program to provide health services for Ohio's senior citizens needing help since 1946. It was expanded in 1955 and again in 1961. The Federal Government through the Mills portion of the Kerr-Mills Law is assuming about 60 per cent of the cost. Close to 5,000 received medical only aid during the final quarter of 1961. These are in addition to the many thousands of persons on the old age pension rolls who receive medical help as well as cash pension payments each month. At present approximately 82,900 persons are on the Ohio old age pension rolls and eligible for medical assistance. The amount paid in the month of May 1962 for medical, hospital, nursing services and drugs for all classes of aid for the aged recipients was $1,543,357, according to the Office of the State Auditor.

"The General Assembly in 1961 appropriated about $33 million for the health care program for the aged. Any part of this amount may be used for



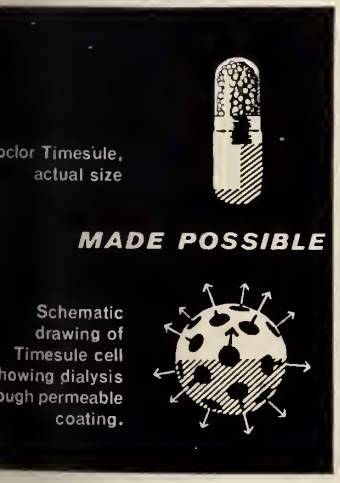
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health services for qualified aged persons whether they need health services only or other monthly assistance in addition to health services. The $33 million granted to the AFA was about $7 million more than amount spent by the Division on health services during the previous biennium.

### Fitted to Need

"General Assembly leaders concluded that Ohio did not need new legislation to take advantage of money offered by the Federal Government for aged health services because Ohio already had a program able to do the job if more Ohio funds would be made available, which was done, and the program expanded accordingly. Legislative leaders felt it would be advisable to require all persons asking aid for aged assistance, whether complete assistance or 'medical only' aid, to meet the same eligibility standards, namely Ohio citizenship and signing of a lien on real property, — requirements which have been in the Ohio Aid for Aged Law for years. The citizenship and lien requirements are prohibited under the Kerr portion of the Kerr-Mills Law but are permissible under the Mills section of the law which provides Federal funds for public assistance programs generally, including Aid for the Aged programs.

"Early in the 1961 session of the State Legislature when proposed Kerr-Mills enabling legislation was introduced, the Ohio State Medical Association supported the bill, along with representatives of organized labor, welfare organizations and others.

"However, when it became apparent that the legislative leaders felt that legislation was not necessary, but gave assurance that additional funds would be appropriated to enable the Division of Aid for the Aged to expand the existing health care program to include 'medical only' cases, the State Medical Association decided to go along with the legislative leaders. Active support was given by OSMA representatives to the move to enlarge the aid for aged appropriations for medical care activities through conferences with legislative leaders and members of the House and Senate finance committees.

"Should additional Ohio funds be required to properly finance the 'medical only' program for needy aged, the State Medical Association will be among the first to support this request from the 1963 General Assembly. If new state legislation is deemed necessary, the Association will support any sound proposal."

In conclusion, Dr. Hamwi reiterated: "Those who say Ohio is not providing an active medical assistance program for the needy aged are either uninformed or misinformed. Ohio is receiving Federal funds under the Kerr-Mills Law for this medical care program. Ohio has a medical care program of long standing for aged Ohioans needing help — a program which is superior to those in most of the other states."

### Institute on Athletic Injuries Scheduled at Ohio State

The program and reservation form for the Second Postgraduate Program for Physicians on Medical Aspects of High School Athletics was mailed with the June issue of the OSMAgram. Deadline for reservations is August 15.

The institute, which will be held August 29 and 30 at the OSU College of Medicine, is designed primarily for physicians who work with Ohio's high school and college athletic teams or serve as medical advisers to coaches and athletic departments.

Fee for the course is $20 and reservation may be obtained by letter by writing to Mr. Hart F. Page, the Institute Treasurer, Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio.

A block of rooms has been set aside at Ohio Stater Inn, 2060 North High Street, Columbus 1, Ohio, (across from the campus). Physicians planning to attend should write immediately for reservations at the Inn, or at the hotel or motel of their choice, since Columbus accommodations will be crowded during this period because of the Ohio State Fair.

Sponsors of the institute, in addition to the OSMA are the Ohio High School Athletic Association and the OSU College of Medicine.

### Grant Furthers Cardiac X-Ray Technique

The John A. Hartford Foundation Inc., has granted $258,000 to the Cleveland Clinic Foundation for a three-year research program to develop new diagnostic techniques and equipment for arterial surgery, catheterization laboratory enlargement and educational improvements.

A joint announcement by Ralph W. Burger, Hartford Foundation president, and Richard A. Gottron, Cleveland Clinic Foundation vice president, stated that the funds would be used principally to further the work of Dr. F. Mason Sones, Jr., in developing new arterial photography techniques and instruments for mechanical removal of arterial obstructions.

Dr. Sones, head of the Cleveland Clinic Cardiac Laboratory, has developed a method to take high-speed x-ray pictures of human coronary arteries.

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Two Cleveland residents at the Cleveland Clinic Foundation received honorable mention for their exhibit at the recent annual meeting of the Student American Medical Association in Washington, D. C. They are Dr. Arjun G. Sehgal and Dr. H. William Goebert, Jr., whose exhibit was entitled "Intraspinal Corticosteroids in the Management of Sciatica."

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# Ad Astra

Everett Marquis Chalker, M. D., Cleveland; Ohio State University College of Medicine, 1934; aged 51; died June 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Chalker practiced in Warren before World War II. At the outbreak of the war he went into military service and became a career Air Force surgeon. In 1958 he retired from military life and became physician for the American Steel & Wire Division of the U. S. Steel Corporation. Survivors include his widow, a daughter and a brother, Dr. Harry E. Chalker, of Girard.

Donald Carlton Darrah, M. D., Cleveland; Western Reserve University School of Medicine, 1930; aged 60; died May 13; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Darrah served all of his professional career in the Cleveland area where he was vice-president of the staff at St. Vincent Charity Hospital and former clinical instructor at Western Reserve. He was surgeon for many years for the Nickel Plate Railroad. Survivors include his widow and three daughters.

John Stewart Deyell, M. D., Ravenna; University of Toronto Faculty of Medicine, 1925; aged 61; died May 15; member of the Ohio State Medical Association and the American Medical Association. A native of Canada, Dr. Deyell did graduate work in Pennsylvania, New York and Cleveland before opening his practice in Ravenna where he practiced for 33 years. He was a member of the Congregational Church, the Order of Elks and the Masonic Lodge. His widow survives.

George H. Donnelly, M. D., Akron; University of Buffalo School of Medicine, 1928; aged 59; died May 1; member of the Ohio State Medical Association and the Industrial Medical Association; Fellow of the American College of Surgeons. A native of Bradford, Pa., Dr. Donnelly was a former career military surgeon, having served with the Army Medical Corps from 1928 to 1955.

Remer Leroy Haines, M. D., Jamestown; Ohio State University College of Medicine, 1913; aged 73; died May 10; member of the Ohio State Medical Association and the American Medical Association. A native of Greene County, Dr. Haines returned there to practice on completion of his medical training. He practiced first at Paintersville, moving in 1925 to Jamestown where he organized the hospital. For 16 years he was Greene County coroner and for many years was surgeon for the B. & O. Railroad. He was a member of the Lions Club, several Masonic bodies, the local board of public affairs and the Methodist Church. Surviving are his widow, three daughters and a son, Dr. Russell Haines, a Xenia area dentist.

Otho L. Hawk, M. D., East Cleveland; Western Reserve University School of Medicine, 1927; aged 59; died May 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Hawk practiced for more than 30 years in the East Cleveland area. A veteran of World War II, he was a member of the Church of the Savior. Survivors include his widow, two daughters and his mother.

Robert Armstrong Kidd, M. D., Columbus; Eclectic Medical College, Cincinnati, 1929; aged 58; died



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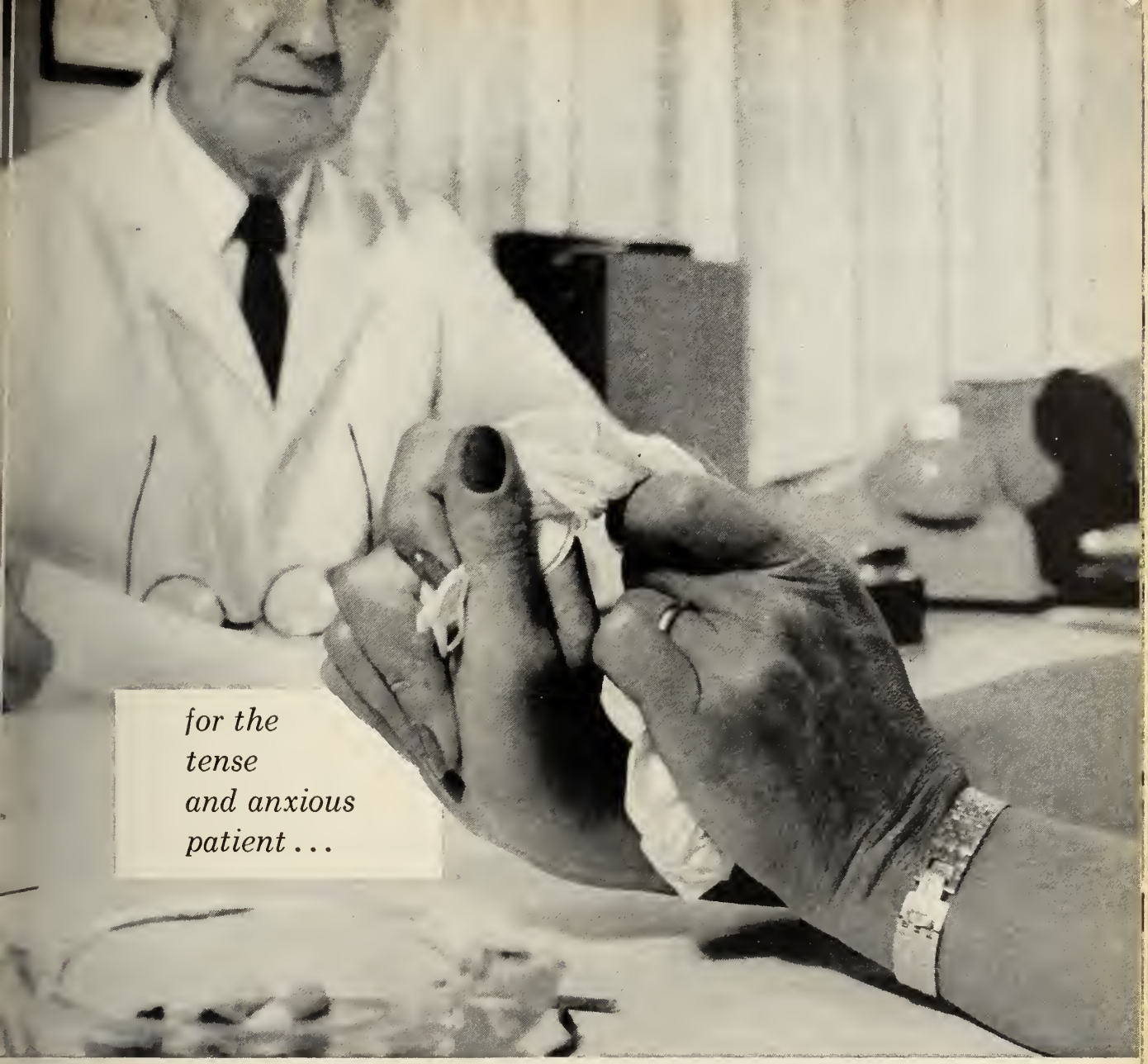
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May 21; member of the Ohio State Medical Association, the American Medical Association and the American Psychiatric Association. A practicing physician in Columbus for many years, Dr. Kidd was president and physician in charge of the McMillen Sanitarium. A Navy surgeon during World War II, he attained the rank of lieutenant commander. Affiliations included membership in the Masonic Lodge. Surviving are his widow, a daughter, two brothers and two sisters.

Frank John Lehmann, M. D., Toledo; Toledo Medical College, 1897; aged 85; died May 29. After 35 years of practice in Toledo, Dr. Lehmann retired in 1937. He was a veteran of World War I. Survivors include two sons and two daughters.

Norman Stephan Manica, M. D., Cleveland; University of Buffalo School of Medicine, 1945; aged 48; died May 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Manica served in the Navy Medical Corps during World War II, and began his practice in Cleveland in 1949. Surviving are his widow, a son, a daughter and his mother.

Simon Morgenroth, M. D., Akron; Medical College of Ohio, Cincinnati, 1900; aged 84; died May 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Morgenroth's practice in Akron extended from 1904 until his retirement about 10 years ago. He was a member of the Rotary Club, the Masonic Lodge and the Akron City Club. Surviving are his widow, a son and a daughter.

Howard James Murphy, M. D., Toledo; University of Michigan Medical School, 1926; aged 61; died early April; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Murphy had been a practicing physician in Toledo for more than 30 years.

Mary Tracy Arnold Poling, M. D., Maumee; University of Michigan Medical School, 1937; aged 54; died May 3; member of the Ohio State Medical Association and the American Medical Association. A resident of Maumee since 1956, Dr. Poling was staff physician for the Toledo State Hospital. Formerly she was health commissioner for Seneca County, having come to Ohio from Kentucky in 1944. A member of the Episcopal Church, the Altar Guild and the Evening Guild, she is survived by her husband, Carl M. Poling, two daughters, a son and a sister.

John Eugene Shorb, M. D., Canton; Ohio Medical University, Columbus, 1903; aged 81; died April 29; former member of the Ohio State Medical Association; member of the American Roentgen Ray Society. An earlier resident of Canton, Dr. Shorb returned there to practice on completion of his medi-


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Gynecology, Office & Operative, Two Weeks, Sept. 17
Proctoscopy & Sigmoidoscopy, One Week, September 10
General Practice Review, One Week, October 8
Gallbladder Surgery, 3 Days, October 8
Surgery of Hernia, 3 Days, October 11
Basic Electrocardiography, One Week, October 1
Board Review, Internal Medicine—Part I, Sept. 10
Advances in Medicine, One Week, October 15
Advances in Surgery, One Week, December 10
Blood Vessel Surgery, One Week, October 22
Board of Surgery Review, Part I, Two Weeks, Nov. 5
Board of Surgery Review—Part II, Two Weeks, Nov. 26
Fractures & Traumatic Surgery, Two Weeks, October 1

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cal training. He was one of the pioneer specialists in radiology. A member of the Methodist Church, he is survived by his widow.

Walter Burns Sloan, M. D., Toledo; Eclectic Medical College, Cincinnati, 1921; aged 69; died May 14; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Henry County and former practitioner in Arcadia, Dr. Sloan moved his practice to Toledo in 1927. He was a former president and member of the board of Roche Hospital. A veteran of World War I, he was a member of the Masonic Lodge and a member of the Ohio Jersey Breeders' Association. Survivors include his widow, a daughter, two sisters and three brothers.

Robert Joseph Tapke, M. D., Cincinnati; University of Cincinnati College of Medicine, 1932; aged 56; died May 30; member of the Ohio State Medical Association; Fellow of the American College of Surgeons and the International College of Surgeons; diplomate of the American Board of Surgery; past-president of the Cincinnati Surgical Society. A practicing surgeon in Cincinnati since 1937, Dr. Tapke had recently been named president-elect of the staff of Good Samaritan Hospital. A major in the Medical Corps during World War II, he is survived by his widow, two daughters, two sisters and a brother.

Berger Thomas, M. D., Columbus; Ohio State University College of Medicine, 1931; aged 55; died June 2; former member of the Ohio State Medical Association. A medical officer in the Navy during World War II, Dr. Thomas recently had been associated with the Ohio Bureau of Workmen's Compensation. A brother survives.

George Byron Watson, M. D., Adelphi; Ohio State University College of Medicine, 1928; aged 61; died May 25; member of the Ohio State Medical Association and the American Medical Association. A former surgeon of Columbus and member of the faculty at Ohio State University College of Medicine, Dr. Watson went into semi-retirement in 1954 and opened an office for general practice in the Hocking County community. He served in the Army Medical Corps during World War II and held the rank of major. Cousins survive.

Howard William Williamson, M. D., Toledo; Chicago College of Medicine and Surgery, 1916; aged 75; died May 8; member of the Ohio State Medical Association and the American Medical Association. A life-long resident of Toledo, Dr. Williamson returned there after serving with the Army Medical Corps during World War I. He was associated for two years with the Veterans Administration before opening his practice in 1924. Survivors include his widow, a son and a daughter.

## Postgraduate Courses Announced At Ohio State University

The Ohio State University College of Medicine has a number of postgraduate courses scheduled in months to come. Following are subjects and dates of courses in the near future. Those interested are advised to contact respective department heads at the University for further information.

Practical Perimetry (for Office Assistants), August 6-7-8.

Conference on Athletic Injuries, August 29-30. (Co-sponsored by Ohio State Medical Association.)

Aerospace Medicine, September 10-14.

Contact Lens Procedures (for Ophthalmologists and their Assistants), September 17-18.

Psychiatry Seminar—David Beres, M.D. (Functions of the Ego), September 21.

Diagnosis and Treatment in Gastroenterology, September 21-22.

Pulmonary Disease Postgraduate Course, September 28-29.

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Two grants of $5000 each have been given to the College of Medicine at the University of Cincinnati for purposes of medical research. One grant was given by Smith Kline and French Foundation and the other by the Eli Lilly Co.


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# Activities of County Societies . . .

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### CLINTON

A program of Sabin oral polio vaccine was discussed by the Clinton County Medical Society at a recent luncheon meeting. Dr. Mary Boyd, county health commissioner, reported that a medical self help plan, for cases of medical emergency, is being shaped by the Civil Defense Department. Instruction and training kits will be made available.

### HAMILTON

Dr. Richard H. Marshak, associate radiologist at Mt. Sinai Hospital, New York City, addressed a recent meeting of the Academy of Medicine of Cincinnati. Dr. Marshak's topic was "Recent Advances in Gastrointestinal Radiology."

## Second District

(COUNCILOR: GEORGE J. SCHROER, M. D., SIDNEY)

### MIAMI

The annual joint meeting of the Miami County Medical Society and the Miami County Medical Auxiliary was held in May at the home of Dr. David Brown.

### MONTGOMERY

Brig. General David M. Jones, who heads the Air Force's Skybolt development program, was the guest speaker at the annual meeting of the Montgomery County Medical Society. At the meeting, held at the Wright-Patterson Air Force Base Officer's Club, General Jones spoke on "Gam-87," which is the air-launched ballistic missile.

## Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

### ALLEN

The Lima and Allen County Academy of Medicine recently held a dinner meeting at which the guest speaker was Dr. Charles E. Test, M. C., associate professor of medicine at the University of Indiana Medical School. Dr. Test's subject was "Clinical Approach to Adrenocortical Disorders." The meeting was co-sponsored by the Lima Academy of General Practice.

### HANCOCK

The Hancock County Medical Society has created a speaker's bureau for the purpose of supplying speakers from society for meetings throughout the county. Talks on various topics concerning medicine and surgery will be available for the coming season.

In other action, the Society went on record favoring the mass inoculation of people with the Sabin oral polio vaccine. Plans to implement this type of program in Hancock County are in the early stages of development.

## Fourth District

(COUNCILOR: EDWIN R. MURBACH, M. D., ARCHBOLD)

### OTTAWA

The May meeting of the Ottawa County Medical Association was held at the Port Clinton Beach Club. Guest of honor at the dinner-meeting was hospital superintendent Florence Specht. At the meeting, plans were made for the annual picnic for hospital personnel.

## Fifth District

(COUNCILOR: HENRY A. CRAWFORD, M. D., CLEVELAND)

### CUYAHOGA

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as president of the Cleveland Academy of Medicine. He succeeded Dr. John D. Osmond, Jr. Dr. William E. Forsythe, vice-president, was named president-elect. Dr. Middleton H. Lambright was elected vice-president.

New trustees for three-year terms are Drs. Peter Coppedge, L. Philip Longley, Frederick A. Oldenburg, Myron L. Pardee, John R. Reed, John H. Sanders, Elden C. Weckesser and Julius Wolkin.

* * *

In May, the Cleveland Academy of Medicine and the Health Council of Greater Cleveland sponsored a Conference on Social Health. At the luncheon session the guest speaker was Dr. William J. Brown, chief of the venereal disease branch of the U. S. Public Health Service. His topic was "Venereal Disease Education Can't Wait."

The afternoon session consisted of a panel presentation on the theme, "Sex Education: Home, School, Religion, Physician, Community Agencies."

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

### BELMONT

At the June meeting of the Belmont County Medical Society, Dr. D. Franklin Milam, Chairman of the Department of Urology, West Virginia University School of Medicine, was the guest speaker. Dr. Milam's topic was "Diagnosis and Treatment of Renal Hypertension."

## Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, ZANESVILLE)

### WASHINGTON

Members of the Washington County Medical Society met recently at the Wakefield Hotel, Marietta. They heard a discussion on "Treatment Problems in State Hospital Psychiatry." The speaker was Dr. Richard Lilly of Parkersburg, W. Va., former superintendent of West State Hospital.

## Ninth District

(COUNCILOR: CHESTER H. ALLEN, M. D., PORTSMOUTH)

### JACKSON

At a recent meeting of the Jackson County Medical Association, the social security office of Portsmouth presented a program covering the disability provisions of the Social Security Act. The program was presented by John R. Chatfield and William Greber, manager and field representative respectively, of the Portsmouth office.

### SCIOTO

At the May meeting of the Scioto County Medical Society, attorneys Bruce Lane and D. H. McKinney of Cincinnati presented a discussion of the topic "Establishing a Professional Corporation and Tax Benefits to be Derived Therefrom."

## Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

### ROSS

The Ross County Medical Society recently sponsored a public meeting for discussion of the medical care of the aged through Social Security Bill, H. R. 4222. The speaker was Bernard P. Harrison, J. D., of Chicago, who is legislative attorney for the American Medical Association.

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

"Radiation Injuries" was the topic of discussion at a recent meeting of the Lorain County Medical Society. At the Society's 15th annual meeting, a team from the Rochester University School of Medicine and Dentistry Atomic Energy Project, under Dr. Marylou Ingram, presented the program.

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### Announcement in Regard to Service In Air Force Reserve Program

The following announcement was received from the Clinton County Air Force Base and is presented for the benefit of physicians interested:

Doctors without military service may now fulfill their military obligation by obtaining a commission in the Air Force Medical Corps and participating in the Air Force Reserve program, Colonel Donald J. Campbell, commander of Clinton County AFB and the 302d Troop Carrier Wing (Reserve), announced.

Immediate openings for doctors exist in the 302d Troop Carrier Wing at Clinton County AFB. Air Force Reserve members of the 302d train one weekend a month and 15 days during the summer. Doctors can obtain help in applying for a commission and more facts about the Air Force Reserve program by contacting the 302d at CCAFB, Wilmington, Ohio.


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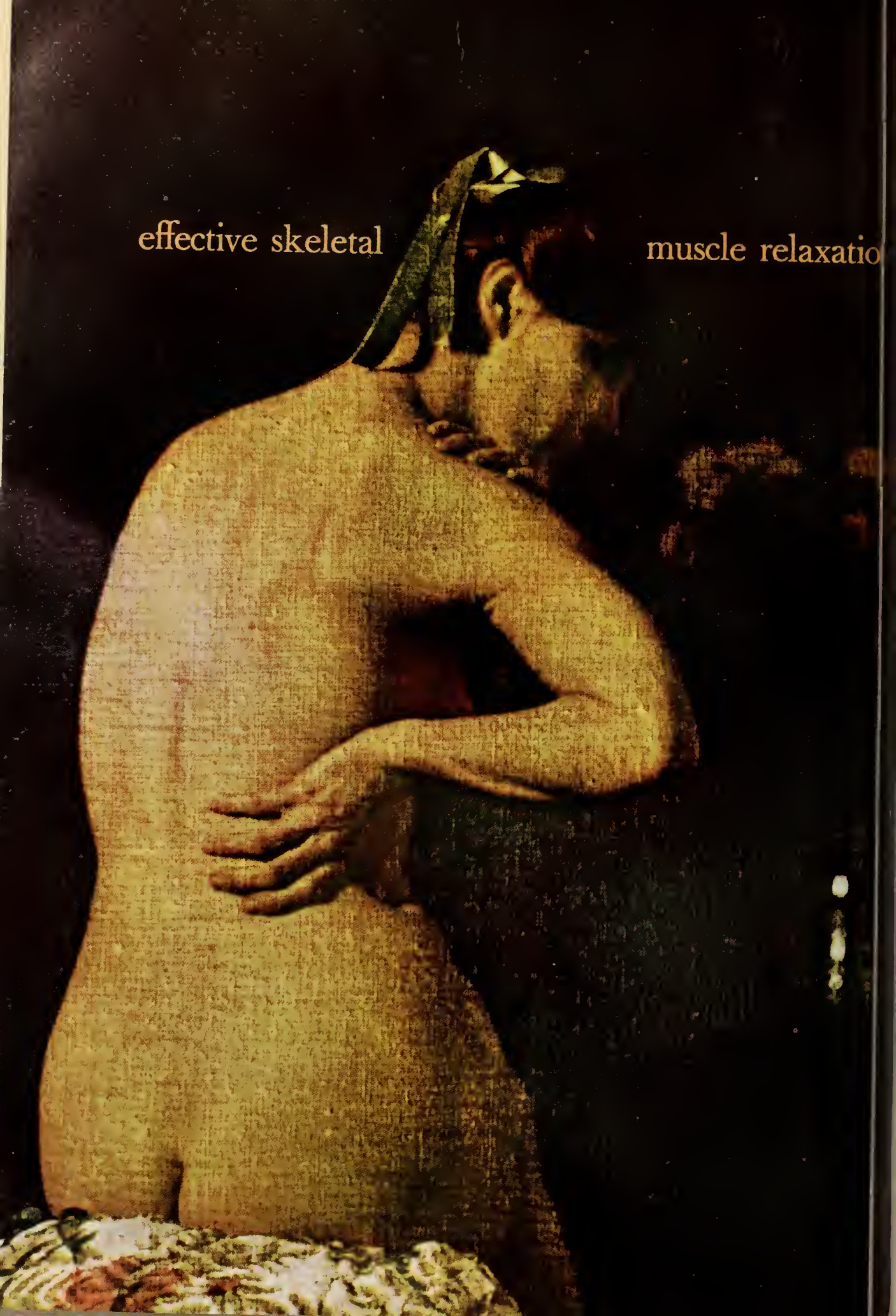
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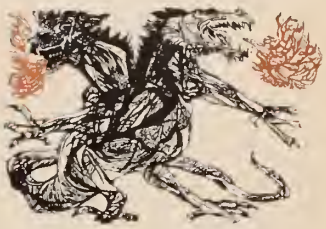
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| Phenacetin | 97 mg. | Hyoscyamine sulfate | 0.016 mg. |
| | | Phenobarbital (⅛ gr.) | 8.1 mg. |

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**References:** 1. Carpenter, E. B.: South. M. J. 51:627, 1958. 2. Hudgins, A. P.: Clin. Med. 8:243, 1961. 3. Lamphier, T. A.: J. Abdomin. Surg. 3:55, 1961. 4. Levine, I. M.: Med. Clin. N. America 45:1017, 1961. 5. Meyers, G. B., and Urbach, J. R.: Penna. M. J. 64:876, 1961. 6. Perchuk, E., Weinreb, M., and Aksu, A.: Angiology 12:102, 1961. 7. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 8. Schaubel, H. J.: Orthopedics 1:274, 1959. 9. Steigmann, F.: Am. J. Nursing 61:49, 1961.

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"...unusual freedom from toxicity..."[1]

# Activities of Woman's Auxiliary . . .

## CUYAHOGA

CHAIRMAN, PUBLICITY COMMITTEE — Mrs. Rivington Fisher, 549 Eastmoor Blvd., Columbus 9, Ohio.
(Roster of Officers, Page 867)

Mrs. Edward Bauman of Warren, Ohio, President of the Ohio State Medical Association Auxiliaries, installed the officers and directors for the year 1962-63 at the annual meeting of the Woman's Auxiliary of Cuyahoga County on Monday, May 28th, at Cleveland. Mrs. Eugene W. Gessler was installed as president; Mrs. C. L. Hudson, president-elect; Mrs. W. N. Macey, vice-president; Mrs. F. M. Friemann, recording secretary; Mrs. R. W. Kapp, corresponding secretary; Mrs. W. J. Zeiter, treasurer; and Mrs. Francis L. Browning, assistant treasurer.

Directors installed were Mrs. John Budd, Mrs. J. F. Corsaro, Mrs. W. E. Forsythe, Mrs. W. J. Gardner, Mrs. T. L. Manning, Mrs. H. H. Pevaroff, Mrs. J. E. Wallace, and Mrs. S. N. DeVille.

Mrs. Gessler, the newly installed president, attended LaGrange College, LaGrange, Ill., and has been active in civic and club projects in Cleveland ever since her marriage to Dr. Eugene Gessler. She has two grown children, a son Dick working in Cleveland and a daughter Mary Ann attending University of Miami in Coral Gables, Florida.

At the Ohio State convention just concluded in Columbus Mrs. J. N. Wychgel was made first vice-president of the state, Mrs. C. A. Colombi, state parliamentarian, Mrs. Fred Rittinger, legislation and board director, Mrs. J. B. Hazard, health careers chairman and board director, and Mrs. Frank Meany, Fifth District director. Also at the May convention the legislation recommended by the Cuyahoga County Auxiliary favoring financial aid for High School Driver education, driver safety training courses and repeat physical examinations, and Crusade for Seat Belt legislation were all favorably received and passed.

## HAMILTON

"Summer Terraces Are for the Birds" was the timely topic of Mr. Robert Kendall, interior decorator, AID, when he delighted the Auxiliary's May 22 luncheon meeting at Maketewah Country Club with his tongue-in-cheek remarks. Mrs. Robert Krone, program chairman was assisted by Mrs. Clavin Warner. Mrs. Frank Cleveland, who was hospitality chairman for the day, had Mrs. John Payne as her vice-chairman. Mrs. Charles Work was responsible for the clever decorations.

At the business meeting which followed, Mrs. Carl F. Schilling announced that Hamilton County had again won highest honors for excellence above requirements at the recent convention held in Columbus.

Newly-elected officers were installed by Mrs. Warner, who herself is president-elect of the State Auxiliary. Serving the local Auxiliary in 1962-63 will be Mrs. J. Sterrett Caldwell, president; Mrs. I. C. Sharon, vice-president; Mrs. Byron E. Boyer, recording secretary; Mrs. Carl E. Rousch, corresponding secretary; and Mrs. Joseph E. Ghory, treasurer. New directors are Mrs. Earl Van Horn, Mrs. Harry Hines, and Mrs. Makoto Yamaguchi.

Mrs. Schilling was presented with a Past-President's pin and Mrs. Caldwell gave a short speech of acceptance after receiving a rose-decorated gavel from Mrs. Schilling.

## SCIOTO

Mrs. Jack D. MacDonald will serve as president of the Woman's Auxiliary to Scioto County Medical Society in the coming year. Mrs. MacDonald and other officers were installed following the auxiliary's

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annual May breakfast in the home of Mrs. H. M. Keil, Portsmouth.

The installation was conducted by Mrs. G. E. Neff, a past-president. Other new officers are Mrs. Jerome Rini, president-elect; Mrs. Spencer W. Miller, vice-president; Mrs. L. B. Hatch, secretary; Mrs. B. U. Howland, treasurer; Mrs. Robert N. Counts, historian, and Mrs. Chester H. Allen and Mrs. Louis R. Chaboudy, advisory board members.

Arrangements of spring flowers decorated the Keil home and pansies were used as favors at each place setting.

The retiring president, Mrs. Chaboudy, thanked the retiring corps of officers for their work during the last year.

Mrs. Irene Birch was a guest.

The members also held a miscellaneous shower for the Fresh Air Camp.

On the hostess committee assisting Mrs. Keil were Mrs. William C. Hugenberg, Mrs. Jerome Sheets, Mrs. Dow Allard, Mrs. Louis M. Schoettle and Mrs. Ralph W. Louis.

## Public Health Service Announces Audiovisual Function

A central audiovisual function has been established for the U. S. Public Health Service at its Communicable Disease Center in Atlanta.

Formerly the Audiovisual Section, the newly designated National Medical Audiovisual Facility will have responsibility for (1) Development, production, acquisition, distribution, and utilization of medical motion pictures and other audiovisual forms; (2) maintenance of the National Medical Motion Picture Archives; (3) dissemination and exchange of scientific and other medical film information important to progress in medicine and public health; (4) encouraging the development and production of medical films and other audiovisuals; and (5) stimulating a speed-up in the circulation of medical knowledge, on a national and international basis, through audiovisuals.

## President's Council on Aging

President Kennedy has signed an executive order creating a President's Council on Aging to maintain a continuing study of the over-all responsibilities of the Federal Government with respect to the problems of aging and at Kennedy's request a bill H.R. 11752 (S. 3324) had been introduced into Congress authorizing a five-year $50 million program of grants to improve services for the aged through pilot community projects, demonstrations and research programs.

Total membership of the 74 Blue Shield Plans of the country at the end of March, 1962, was 49,252,622, a net gain of 130,458 during the first quarter of the year.

# Buckeye News Notes . . .

**Akron**—Dr. Martha D. Nelson, acting Summit County health commissioner for 22 of the last 36 months, became the county's official health commissioner on June 1.

**Canton**—"Recognition of Coronary Artery Heart Disease" was the subject of a talk at a recent luncheon meeting of the Canton Rotary Club. The talk was given by Dr. Earl K. Shirey, a member of the cardiovascular division of the Cleveland Clinic Foundation. —*Canton Repository.*

**Carrollton**—Dr. William Wasson, Canton surgeon, addressed the local Rotary Club recently. His topic was "Heart Resuscitation and Use of External Defribrilators."—*Canton Repository.*

**Cincinnati**—Dr. Robert L. McLaurin, director of neurological surgery at General Hospital and the University of Cincinnati Medical College, addressed a recent meeting of the Greater Cincinnati Council for Epilepsy.—*Cincinnati Post & Times Star.*

**Cincinnati**—Dr. John H. Skavlem was recently presented the National Tuberculosis Association's Will Ross Medal for distinguished volunteer service.

**Cleveland**—Dr. Morris Fishbein, physician, author and former editor of *The Journal of the American Medical Association,* spoke at the 27th annual meeting of the Mt. Sinai Hospital Women's Auxiliary. Dr. Fishbein's topic was "Follies and Fads in Diet, Drugs and Cosmetics." — *Cleveland Heights Sun Press.*

**Columbus**—Three local doctors recently returned home after spending two months in Peru hospitals bringing modern medical knowledge and skills to that country. They are Drs. John L. Terry, Edwin B. Hamilton, and Brooks Hurd.—*The Columbus Dispatch.*

**Hudson**—Dr. Irvine H. Page, director of research division of the Cleveland Clinic Foundation, spoke on "Science and the Good Life" at the commencement of Western Reserve Academy. — *Akron Beacon-Journal.*

**Lima**—Dr. Thomas J. Roess discussed "Heart Attacks and Coronary Artery Disease" at a recent meet- of the Lima Business and Professional Women's Club. — *Lima News.*

**Lisbon**—Dr. John D. Morley, health director for Akron, was the speaker for the annual meeting of the Columbiana County Public Health League. His topic was "The Health Departments of the Future." — *East Liverpool Review.*

**Steubenville**—Dr. George H. Gray, Pittsburgh, addressed a recent meeting of the Fort Steuben Academy of Medicine. Dr. Gray, who is clinical assistant professor of neurosurgery, Department of Surgery, University of Pittsburgh School of Medicine, discussed "Seizures, Shenanigans and Surgery."—*Steubenville Herald Star.*

### Registration of Medical Radiation Sources To Start in July

THE Ohio Department of Health has announced its intention to register all radiation sources in Ohio as required by Section 3701.91 of the Revised Code and the rules and regulations adopted by the Public Health Council.

Application forms for the registration of medical radiation sources will be mailed to all physicians in Ohio during the months of July and August of this year. Physicians need not apply for application forms since they will be mailed to you as potential registrants under the registration law.

Physicians that maintain equipment at two or more locations must register each location on a separate form. Physicians that are in need of additional forms may secure them from either the local health department or the Ohio Department of Health.

Registration is to cover such sources of radiation as X-ray equipment, radioisotopes, nuclear products, nuclear particle accelerators, and other radiation devices. Among those required to register, in addition to medical users, will be schools, universities, and industries. Regulations call for registration by "every person who produces, uses, or disposes of radiation sources."

**Troy**—Dr. E. Robert Torrence has been elected president of the Troy Lions Club.

**Warren**—Dr. Charles A. Anderson was recently elected president general of the National Society of the Sons of the American Revolution.

**Wooster**—Dr. Ford C. Ganyard spoke on "Geriatrics and Heart Disease" to 55 members of the Sunnyside Club at their May Meeting.—*Wooster Daily Record.*

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FOR RENT IN MARION, Ohio, a Clinic Building, in a good location that will accommodate 4 or more Physicians. The floor arrangement consists in the right wing of a large waiting room, a general office for Secretary-Bookkeeper, an ENT room equipped with an electric Retter outfit and accessories, an X-Ray and dark room, and a Clinical Laboratory. The left wing has a large room for EKG, BMR and an electric automatic apparatus which records the precise systolic and diastolic blood pressure. There are two separate rooms for GYN, proctologic and general examinations. The last room on the left is used for minor dressings, minor accident cases, and parenteral medication. There is a rest room for men in the right wing and one for women in the left. There is a drug room in the rear between the right and left wings and a small waiting room for the X-Ray Department and drug room. There is another small waiting room adjacent to the laboratory and still another small waiting room for minor dressings. The building is heated by a hot water system. The working equipment consists of chairs, desks, and filing equipment. There is GYN, Orthopedic, and general surgery equipment. The owner has a good sized parking lot which can be made available for Clinic patients. Box 270, Ohio State Medical Journal.

ATTENTION, Residents of Ophthalmology or Otolaryngology: Having been forced to retire because of permanent disability, I am offering for sale: Eye Instruments, Ear, Nose and Throat Instruments, and Rhinoplastic Instruments. Most of the instruments are of stainless or rustless steel and in excellent condition. Box 273, c/o Ohio State Medical Journal.

APPROX. 1500 sq. ft. available for General Practitioner or Internist; long lease available at very nominal rental; ample blacktop parking; north area of Columbus; busily traveled streets; next to modern drug store. Box 271, c/o Ohio State Medical Journal.

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PATHOLOGIST: Board eligible or certified for well established specialty group leading to full partnership. Excellent financial arrangements. Group is located in fully accredited hospital with completely new well-equipped, well-staffed laboratory. Furnish complete autobiography in initial reply. Write Box 274, c/o Ohio State Medical Journal.

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GENERAL PRACTITIONER — Immediate opening with established medical group in modern, new, fully equipped clinic in a growing suburb of Cincinnati, Ohio. Starting salary open depending on training, and experience, with additional increments thereafter and opportunity for partnership. One other general practitioner in group for scheduling time off, meetings, and vacations. Write full details regarding self, training, and military status to Box 277, c/o Ohio State Medical Journal.

WANTED: Young American born G. P. as associate, in prosperous rural community, Akron-Cleveland area. No investment needed, guarantee plus, modern offices. Modern hospital facilities. Box 279, c/o Ohio State Medical Journal.

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AVAILABLE. General practice in Cosmopolitian suburb near Columbus, Ohio, includes air-conditioned office complete with ECG, BMR, X-ray, etc.; amazingly low investment required. Excellent opportunity for young physician seeking to establish in a highly desirable, rapidly expanding residential area. Present physician relocating out-of-state, but will make necessary introductions, to insure incoming physician of proper beginning. For complete information, contact Box 282, c/o Ohio State Medical Journal.

WANTED: GENERAL PRACTITIONER willing to assist in large practice in Western Hills of Cincinnati. Excellent opportunity for the ambitious neophyte willing to start in percentage partnership after short preliminary trial. Adequate salary. Write or phone, Elliott A. Hilsinger, M. D., 3180 Harrison Ave., Cincinnati 11, Ohio; 661-1500.

FOR RENT: Office suite in new building, air-conditioned, on ground floor; ample parking. Located near hospital in community needing additional doctors. Reply Box 253, c/o Ohio State Medical Journal.

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The incidence of postoperative wound infections, particularly among debilitated patients, presents a serious hospital problem.[1] These infections are caused in many cases by strains of staphylococci resistant to most antibiotics in common use.[1,2,3] In such instances, CHLOROMYCETIN should be considered, since "...the very great majority of the so-called resistant staphylococci are susceptible to its action."[4]

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CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

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**Warning:** Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

**Precautions:** It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia

**References:** (1) Minchew, B. H., & Cluff, L. E.: *J. Chron. Dis.* **13**:354, 1961. (2) Wallmark, G., & Finland, M.: *Am. J. M. Sc.* **242**:279, 1961. (3) Wallmark, G., & Finland, M.: *J.A.M.A.* **175**:886, 1961. (4) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 14. (5) Hodgman, J. E.: *Pediat. Clin. North America* **8**:1027, 1961. (6) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* **173**:475, 1960. (7) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* **105**:398, 1960. (8) Goodier, T. E. W., & Parry, W. R.: *Lancet* **1**:356, 1959.

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NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran chloride (brand of benzalkonium chloride, refined)

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(hydroflumethiazide, reserpine, protoveratrine A–antihypertensive formulation)

**Early, efficient reduction of blood pressure.** Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"[1]) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents[2-8] provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

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**Each Salutensin tablet contains:** 50 mg. Saluron® (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

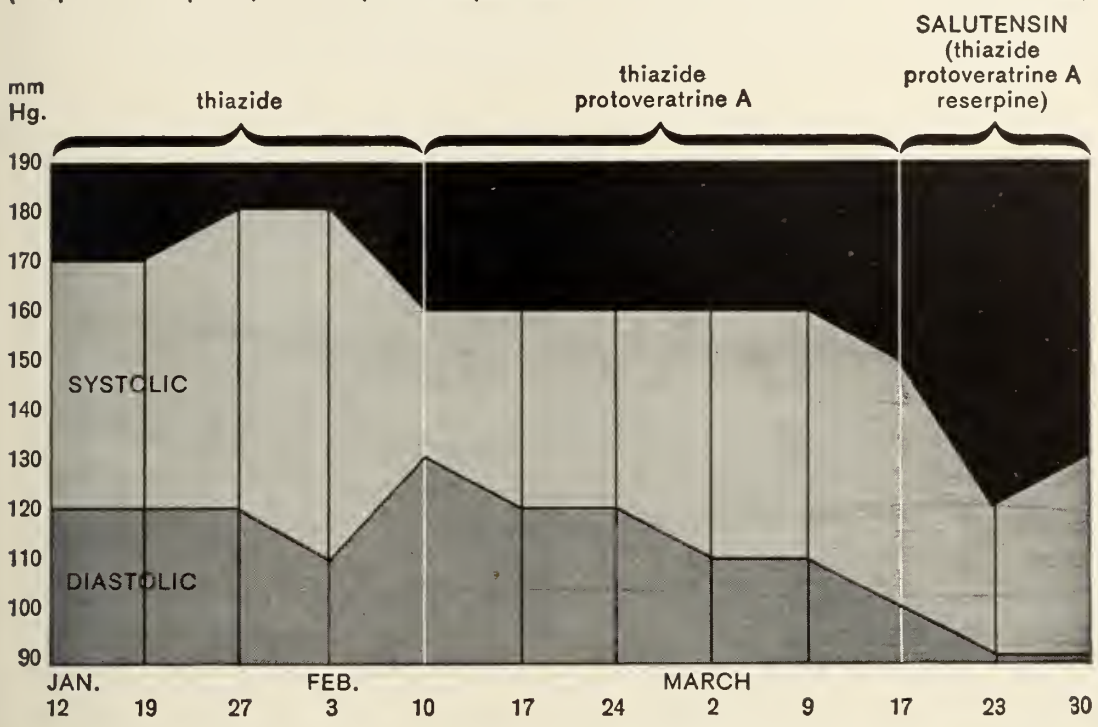
**Supplied:** Bottles of 60 scored tablets.

**References:** 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

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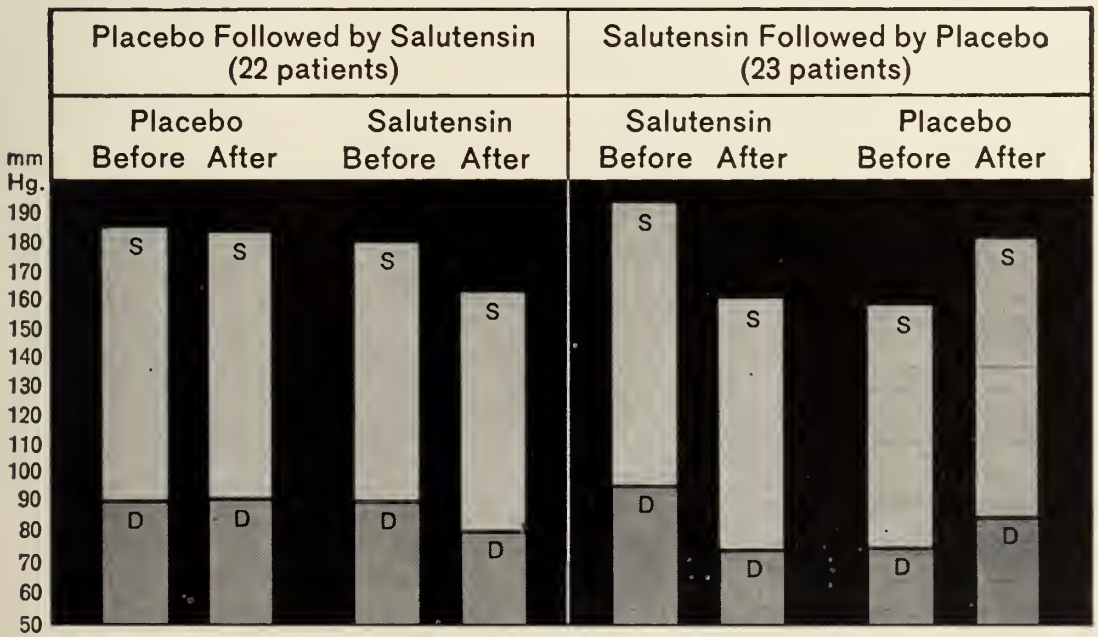
**11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE**

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)




**3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY**

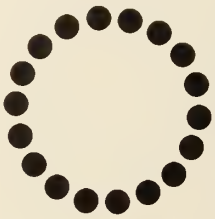
Mean Blood Pressures–Systolic (S) and Diastolic (D)




In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

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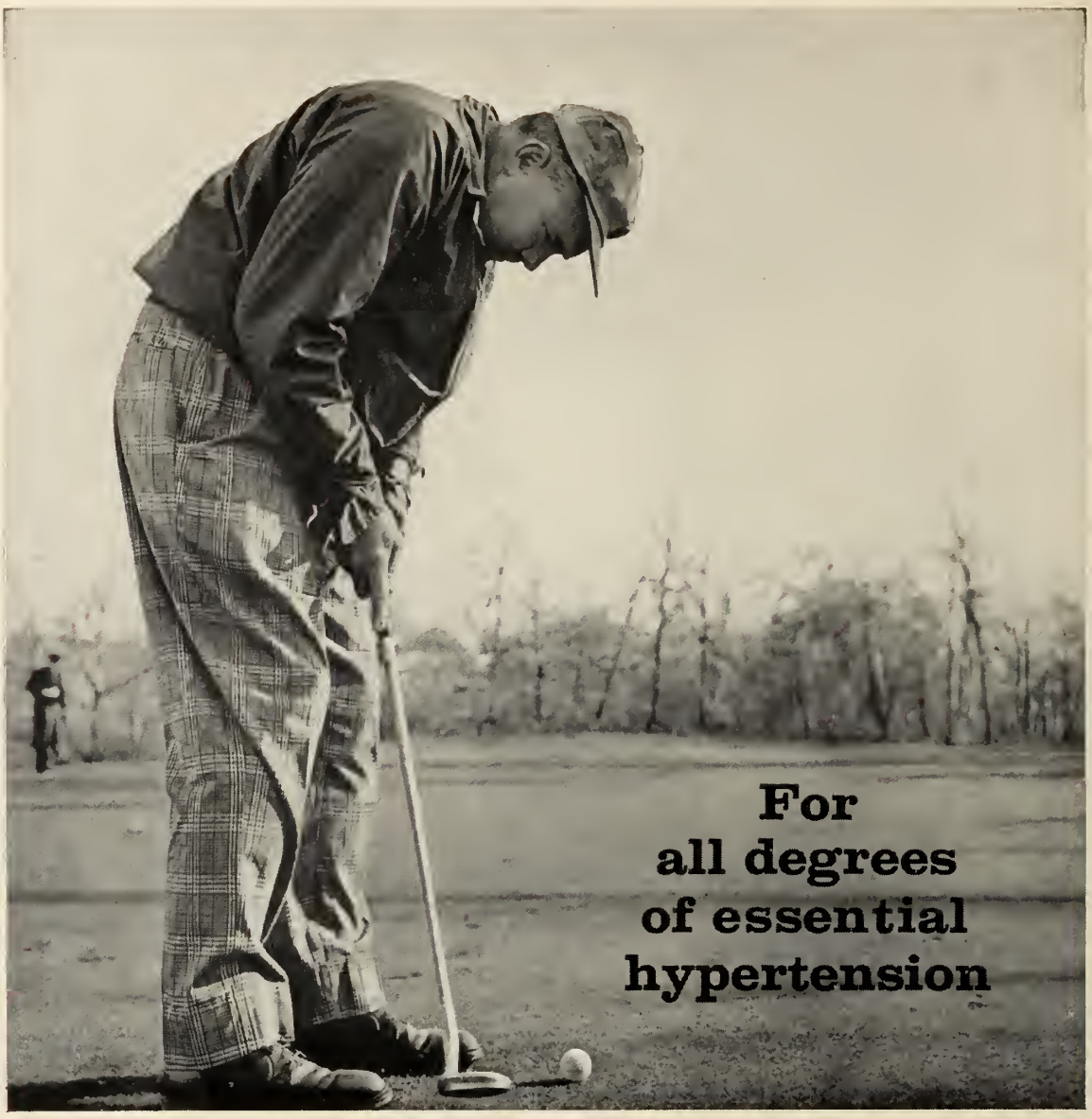
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†Hutchison J. C.: Current Therap. Res. 2:487 (Oct.) 1960.

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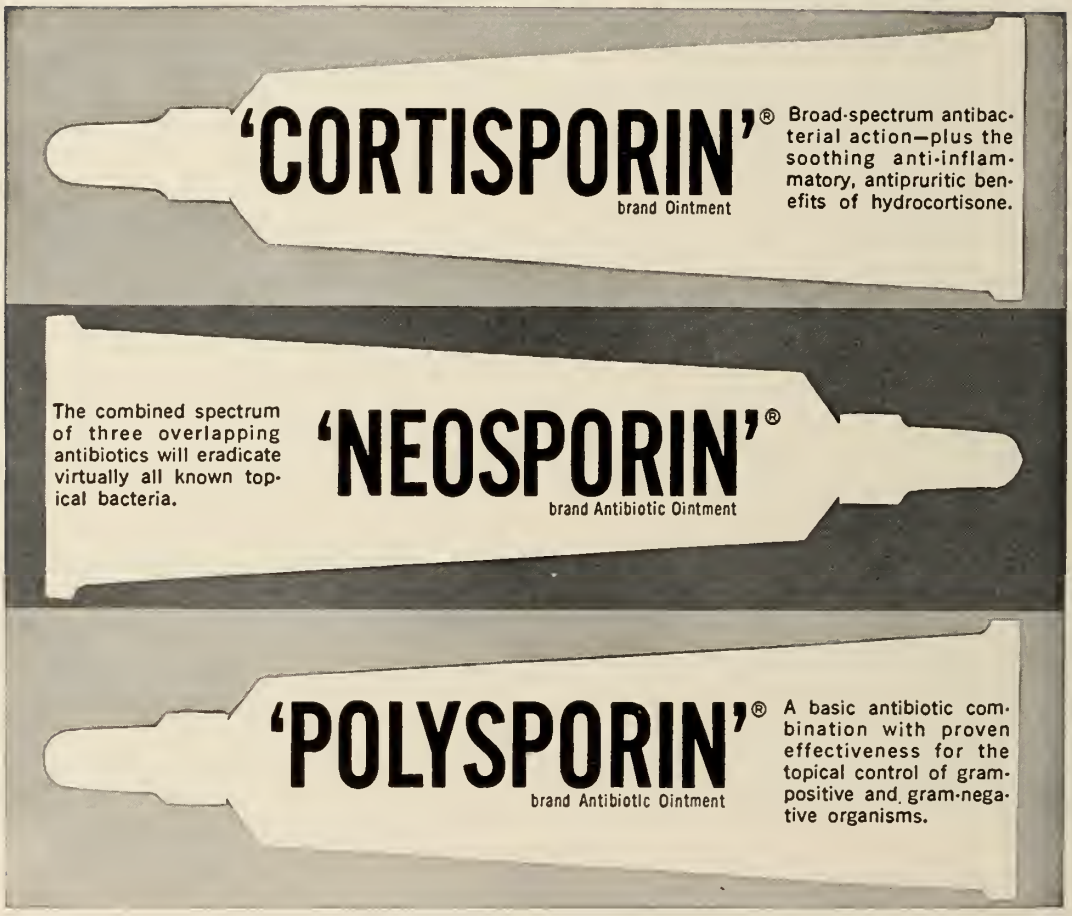
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**Supplied:** Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

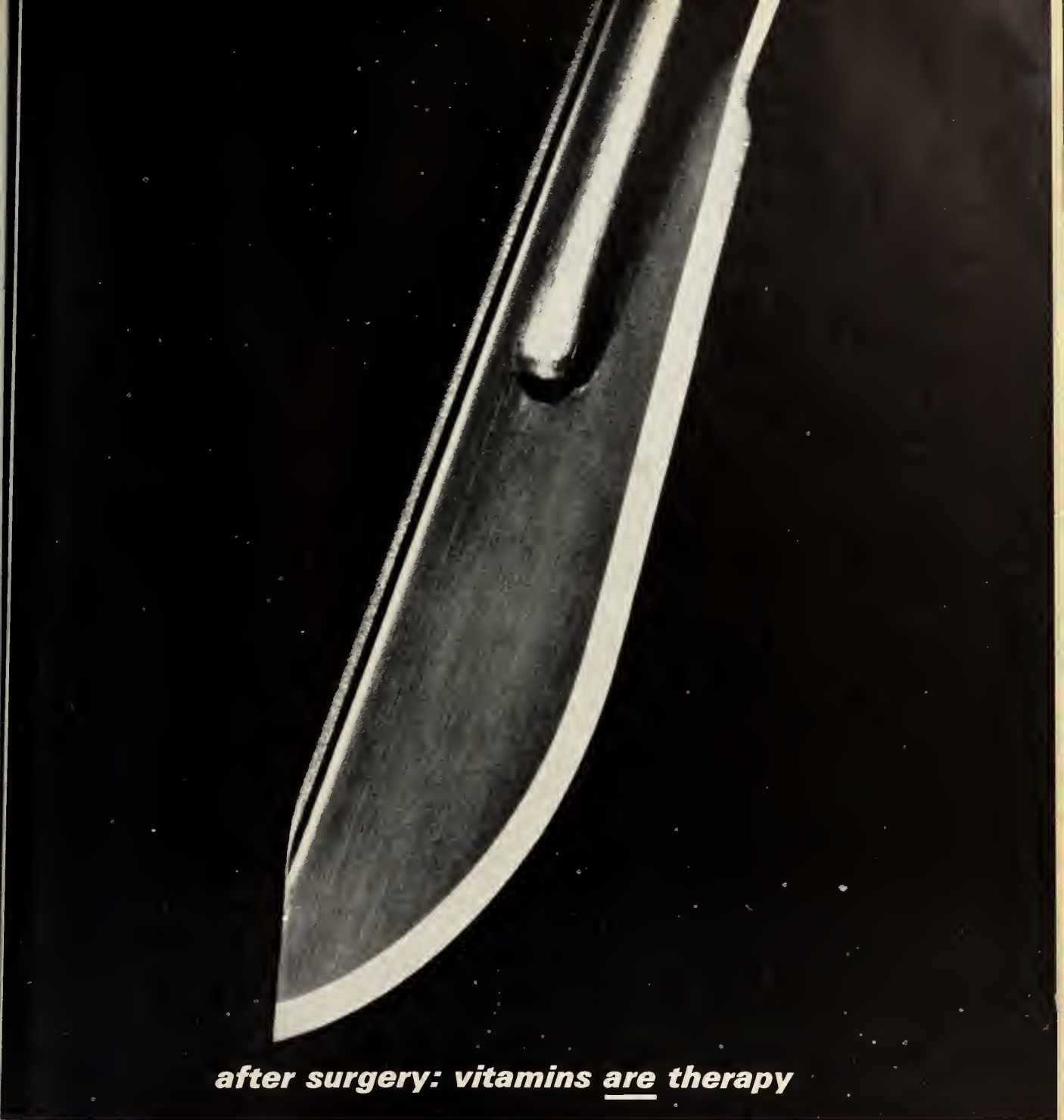
**Caution:** Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.

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Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

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# Medical Care of the Athlete

**Medical Care of the Athlete,** by Allan J. Ryan, M. D., F. A. C. S. ($9.75, 343 p. with 26 illustrations, *The Blakiston Division, McGraw-Hill Book Company, Inc., New York 36, N. Y., 1962).*

In recent years, coaches and trainers in increasing numbers have turned to the medical profession for advice and for medical supervision of athletes. Physicians have generally responded with enthusiasm. Interest and competence in sports medicine have been stimulated by the American Medical Association's Committee on Medical Aspects of Sports. Dr. Ryan, a Fellow of the American College of Surgeons and of the American College of Sports Medicine and an experienced team physician, has been a long-time member of this committee and has just completed a term as chairman. He will be a featured speaker at the Second Postgraduate Institute for Physicians on Medical Aspects of High School Athletics in Columbus at The Ohio State University August 29-30, 1962.

Dr. Ryan's objective has been to provide a convenient reference for physicians who are concerned with athletics, with particular attention to immediate diagnosis and management of medical problems. The book is composed of nine sections. The first, "Getting Together with the Athlete," concerns the subjects of cooperative responsibility for the medical care of athletes, and standards for safeguarding the health of high school, college and professional athletes.

The second section takes up the pre-season physical examination including scope of the examination, medical qualifications for participation in athletics, and an excellent discussion of the desirability of matching competitors on bases of size, age, and abilities.

In "The Medical Supervision of Training" the author describes qualifications and functions of the athletic trainer, and makes a plea for more adequately qualified trainers in high schools and small colleges. He outlines a broad program in which there is more than a coach, necessarily occupied with other matters, could hope to accomplish. The author points out that a school or team physician may find it necessary personally to instruct a trainer who might function in the physician's absence, as, for example, at practice sessions.

In "Common Injuries of Sports and Their Immediate Management" Dr. Ryan discusses the reasons why injuries to athletes require special consideration from the standpoint of diagnosis, treatment and prognosis. In this chapter and one on "Regional Injuries of the Body in Sports, Their Diagnosis and Management" one finds full discussion of the immediate diagnosis and management of the whole gamut of injuries which may occur in sports.

Non-traumatic medical problems such as infections, heat stroke and exhaustion, weight loss, menstrual problems and many others receive necessary attention. It seems unfortunate that, in view of the serious consequences of heat stroke and heat exhaustion in high school sports in Ohio in recent years, these conditions receive only brief attention.

Special hazards of 36 sports (ranging alphabetically from Archery to Wrestling) are described with particular attention to etiology and prevention of injuries. The final chapter concerns the important subject of reconditioning of the injured athlete, and should be particularly helpful to the physician who is not especially qualified in physical medicine.

Descriptions of protective equipment and taping and bandaging are probably not sufficient to qualify a team physician to be an expert in these fields. Other publications devoted exclusively to taping and bandaging are available. Medical knowledge about protective equipment for the head is in developmental stages and is a primary concern of the AMA Committee on Medical Aspects of Sports at the present time.

The reviewer believes that this book is a milestone in a rapidly developing field of medical interest. Here the school or team physician will find help in medical care, psychological counseling, and rehabilitation as well as an understanding of some of the problems of the coach and trainer. The book will also interest and aid coaches and trainers because the need for competent medical care of the athlete is stressed throughout. The sections on medical causes for disqualification from various types of athletics and on rehabilitation of injured athletes would be particularly informative for them.

This book is recommended without reservation for school and team physicians. — By THOMAS E. SHAFFER, M. D., Columbus, Ohio.

**Accident Prevention:** The Role of Physicians and Public Health Workers, published for The American Public Health Association, Inc., Editorial consultant, Maxwell N. Halsey. ($12.00, *The Blakiston Division, McGraw-Hill Book Co., Inc., New York 36, New York.)*

**The Spine:** A Radiological Text and Atlas, by Bernard S. Epstein, M. D. ($16.50, Second edition, *Lea & Febiger, Philadelphia 6, Pa.)*

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## Handbook of Psychiatric Treatment in Medical Practice

**A Storehouse of Practical Advice for the Non-psychiatrist on Handling the Psychiatric Patient!** In simple everyday language, this new book tells you why it is often preferable for the average psychiatric patient to be treated by his family doctor rather than by a psychiatrist. The authors tell you when to refer a patient; which patients you should **not** treat (*arsonists, addicts, homicidal patients, exhibitionists*) and why. Here is only a sample of the problems for which you'll find satisfying answers: *How much psychiatry does the medical practitioner need to know?* Which neurotics should you treat? *What is the prognosis for psychiatric patients?* Do you have time to do psychotherapy? *What are the factors in selecting a psychopharmaceutical?* What are the stigmata of impending suicide? *How to diagnose anxiety?* A special 12-page section lists dosage schedules for all useful psychopharmaceuticals.

By Nathan S. Kline, M.D., F.A.C.P., Rockland State Hospital, Orangeburg, N.Y.; Department of Psychiatry, Columbia University College of Physicians and Surgeons; and Heinz Lehmann, M.D., Verdun Protestant Hospital, Montreal; Department of Psychiatry, McGill University Faculty of Medicine. About 114 pages, 6"x9¼". About $3.50. *New—Just Ready!*

*Just Published!* **Finneson—**

## Diagnosis and Management of Pain Syndromes

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By Bernard E. Finneson, M.D., F.A.C.S., Neurosurgeon, The Episcopal Hospital, Philadelphia. 261 pages, 6½"x9¾", 166 illustrations. $8.50 *New—Just Published!*

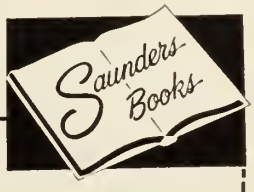
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| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
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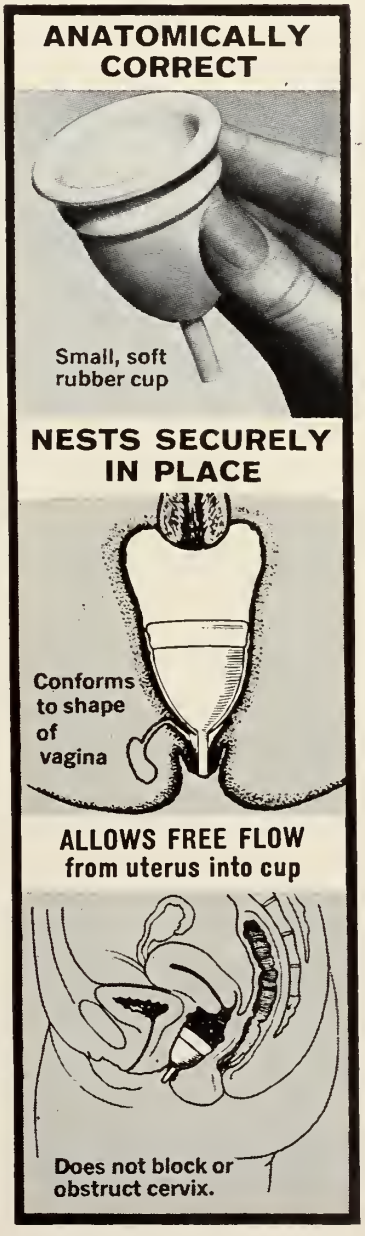
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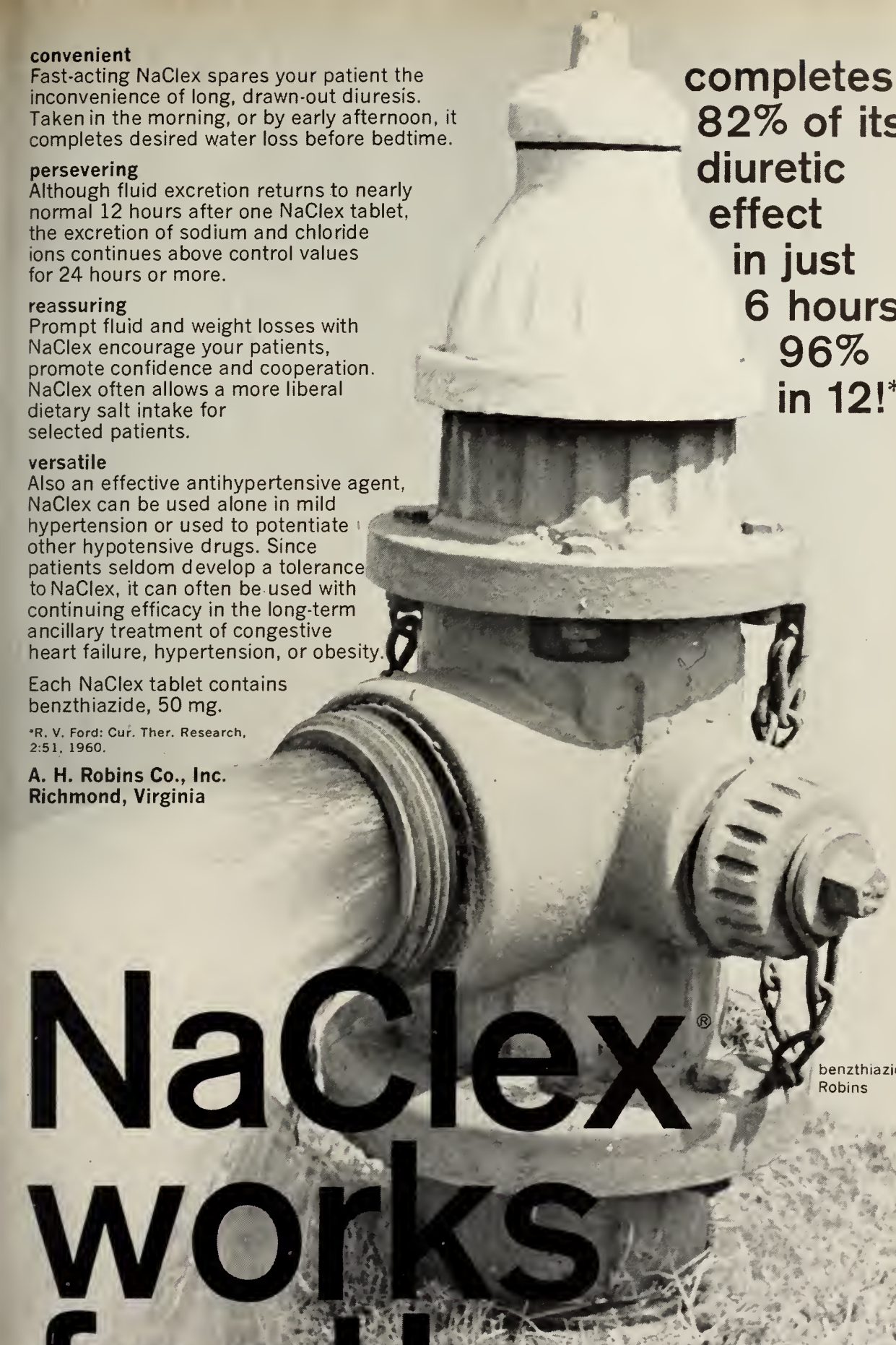
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*R. V. Ford: Cur. Ther. Research, 2:51, 1960.

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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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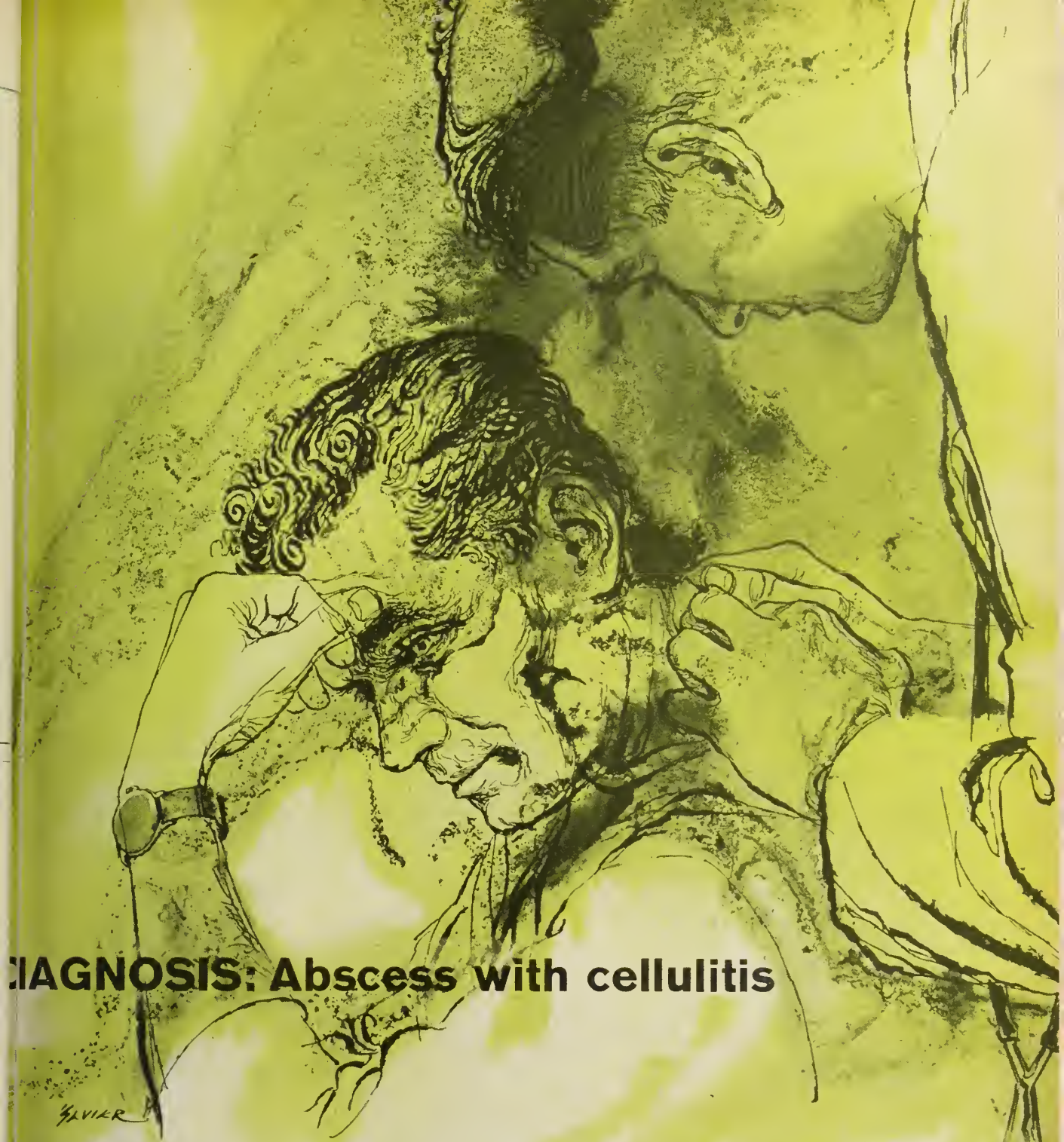
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| Braised Beef and Vegetables | 6½ oz. | 184 | 380 |
| Meat Balls in Brown Gravy | 3½ oz. | 84 | 280 |
| Chopped Chicken Livers | 1 oz. | 31 | 100 |
| Chicken a la King | 3 oz. | 72 | 230 |
| French Style Dressing | 1 tbsp. | 10½ | 60 |
| Brown Gravy | 1 tbsp. | 7 | 21 |
| Applesauce | ½ cup | 48 | 90 |
| Fruit Cocktail | ½ cup | 44 | 90 |
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| Preserves (Peach, Strawberry) | 1 tbsp. | 9 | 55 |
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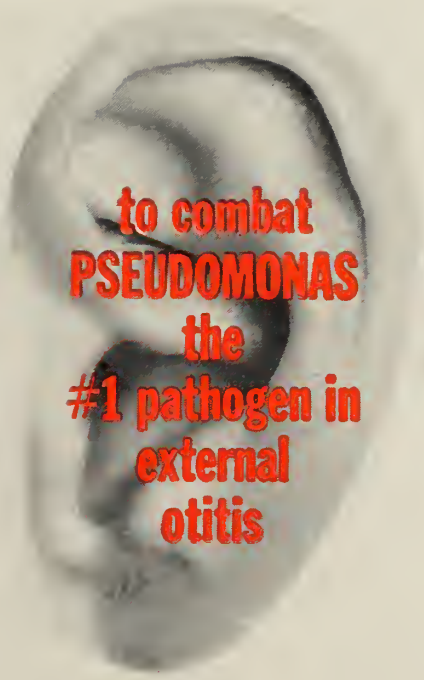
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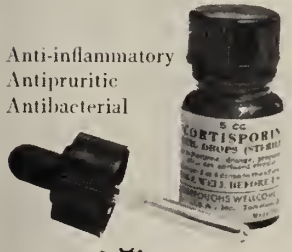
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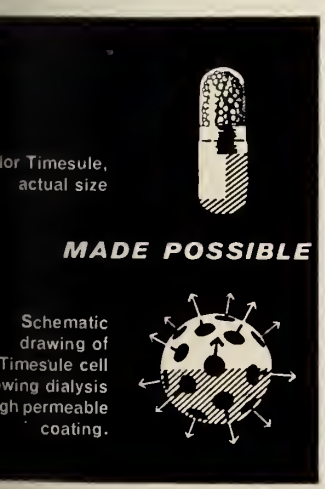
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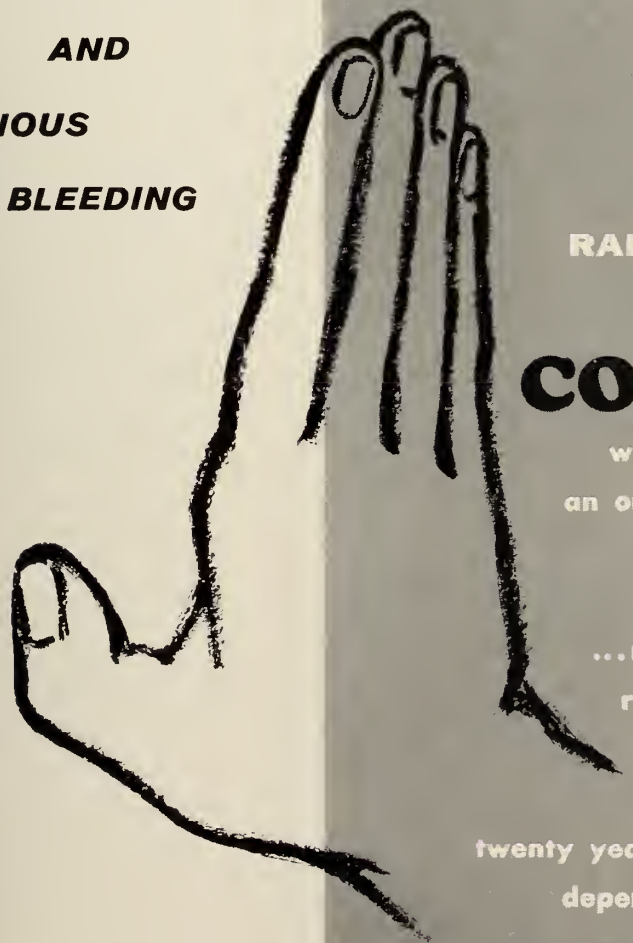
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The Historian's Notebook

# History of the Lakeside Unit Of World War I

HARRY D. PIERCY, M.D.*

## Part IV

*(Continued from July Issue)*

I SHALL not prolong this account of the problems arising out of the care of the sick and the injured. It will be better at this point to recall the lighter and gayer moments. The soldiers and nurses "worked when they worked and played when they played." We might be confined to the hospital for one or several weeks, then would come a period of light duty and we could relax.

### Four O'clock Tea

There was, however, a daily hour of relaxation, long established in the British army, and which we gladly observed. This was the four o'clock hour for tea. There was tea on the wards, in the enlisted men's mess, the nurses' mess and the officers' mess.

In the officers' mess hall Major Withers, Captain Filmer and Rev. Hyde, the Church of England Chaplain, and a dozen or more officers would gather about the tea table and talk and smoke and puzzle over the day's communique. We started out with a pot of tea. When that was gone another good pinch of tea was added then hot water, and at the end of the hour the pot was half full of grounds and the tea was the color of strong coffee. You know, I have never since liked pale tea. Yes! Tea was a useful institution. Occasionally important problems would be discussed and in general it promoted an informal sociability among the members of the mess. It came at the right hour to bolster failing energies and to give a lift to the discouraged and the low in spirit. Tea over, we would go back to the Huts and finish up what was left to be done before dinner at 6:30.

### The Charm of Rouen

Rouen is an old and important city. There was considerable medieval architecture, a beautiful cathedral and the small church, Saint Maclow, was like a jewel. There were good shops and excellent restaurants. During the season there was Grand Opera every Sunday night. The principals and the conductor were brought from Paris. The chorus was local. The performance was always artistic and the total effect was satisfying and well worth the moderate price for the ticket. Sometimes we would attend a High Mass in the Cathedral. I recall one given in memory of Jeanne d' Arc, who was tried in this city and burned at the stake on the old Market Place in 1431.

### The Orchestra

Major Henry Sanford, on our surgical staff, organized an orchestra. There was considerable talent in our command and good musicians were found among our patients. When patients were convalescent they were given an opportunity to "try out" with the orchestra and if they "passed" they were in the orchestra for as long as we could keep them off the discharge list. By this means an orchestra of about 30 players was maintained.

Major Sanford was transferred to the A. E. F. and the orchestra was turned over to me. I had had some baton experience in my college days. In February 1918 we planned a variety show in the style of Lew Dockstader's Minstrels. We arranged four acts, a performance that would run for one and a half hours. The enlisted men, the nurses, and the officers took part in this production. From March 8 to March 15 we gave eight performances to packed houses. Orchestra concerts were given on holidays such as Memorial Day and the Fourth of July. The success of the Unit Show gave us all a good lift in the Unit morale. Fortunately our theatrical efforts were over just in time for us to get straightened around for the spring drive of the Germans and the great load of gassed and injured that descended upon us on March 21st.

### Two Week Leaves

There were leaves for 10 days to two weeks every six months; trips to England, to Paris, Nice, Monte Carlo and other Mediterranean sites. Supplied with orders, bread tickets and sometimes sugar tickets,

*Dr. Piercy, Cleveland, is a member of the courtesy staffs of University Hospitals, and St. Luke's Hospital, Cleveland, Ohio.

Submitted June 23, 1961.



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2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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these fortunate ones got on their way visiting the ancient cities of France and world famous vacation spots. In Southern France there was little to suggest that war was going on, except for the presence of the uniformed soldiers of the Allies who also were on leave.

### The American Vice Consul

An American Consulate was maintained in Rouen. The Vice Consul was Réne Reitenbach, an Alsation, who had spent many years in Franklin, Pennsylvania, and who had become an American citizen. He and his charming wife and young son Richard, lived in a fine brick chalet in the suburb of Boisguillaume. The Reitenbachs gave many dinner parties for the nurses and officers of both No. 9 and No. 12 Base Hospitals. They set a beautifully appointed table on which was served excellent French dishes that were greatly enjoyed by their guests. We became great friends and after the return home, letters and Christmas cards kept that friendship alive.

Upon the invasion of France at the time of World War II, Mrs. Reitenbach wrote to me and told of their difficulties, asking if the officers of the Lakeside Unit would feel like raising a fund for the French Red Cross, she being an officer in the local organization. We accumulated a fund of about $250.00 which was cabled to her in the name of the French Red Cross. This was much appreciated. The ease with which this fund was raised indicated the depth of the good will and friendship created by the Reitenbachs that held over after we departed in 1919.

### British Rations

To return to the gustatory delight of the Reitenbach dinners of 1917, I must mention that we of Gen. Hospital No. 9 were on British rations. There was very little beef and very little sugar and of the latter it should be said that it was coarsly crystalized and mixed with bits of tea leaves. It looked like rock salt. If an officer was late for breakfast he found the sugar bowl empty and his oatmeal and coffee au lait was taken as it was. I recalled the times in Lakeside Hospital when the hilarity in the doctors' dining room led to flipping the butter to make it stick to the ceiling, and lumps of sugar were thrown from one end of the long table to the other. Memories of this wicked waste of food must have bothered the thoughts of many of us when we became conscious of the shortage of these foods in the officers' mess. In place of beef we had Australian hare. These came, frozen, in long shallow crates from the other side of the world. The first few dinners on hare seemed pretty good, but from then on the cook was sorely taxed to find the curry and the herbs that could camouflage the rabbit and make it acceptable.

### The "French Homes Association"

After the Armistice, the French people of Rouen organized the "French Homes Association"; this group was formed to acquaint the Americans with French home life and French hospitality and to cement French and American friendships. We were invited to the homes of the wealthy and of the moderately possessed. The welcome was always warm and informal. The food and the wines were excellent but their homes during the winter months were chilly and even cold. Fuel was scarce and there was no central heating.

The "French Homes" initiated their program by giving a large Tea on December 26, 1918, at the Hotel de Paris. Most of the members were there and Americans from both units. There was tea and gatiaux and some champagne and dancing. Invitations to small home parties were given out. I was invited to Madame Chouillou's for New Year's dinner. The Chouillous had a fine old home near the docks. Across from this were railroad tracks and stacks of steel oil-drums and other water front disarray. The grandpère Chouillou, age 92, was there, active and alert, and he had a bright and sparkling mind. It was a large dinner party, French friends and American officers and nurses from both units, about 20 I should say. There was an excellent dinner and champagne flowed freely, a gay party.

After dinner we retired to the chilly living room where the fireplace had the dull glow of a dying fire. As we were standing, a tray containing a dozen silver thimbles was passed. I took off one and held it to my nose; it had the strong and penetrating odor of apple blossoms. It was calvados, apple brandy, made 62 years before and was still in the wood in the cellar and it was served only on the "jour de l'anne." It was a memorable experience.

The finest French home thrown open to Americans was that of M. and Mme. Pellerin living some miles east of Rouen. A rather large estate and an imposing residence, to the right of which was an artificial circular lake 100 or more feet in diameter. Officers and nurses were repeatedly invited to this delightful home. M. Pellerin had the oleomargarine monopoly for Normandy and there was evidence that this was a profitable business. The beauty and grace of the table service and the food were not excelled wherever else we were invited.

The wines were carefully chosen and the maid would whisper the vintage and the "year" in your ear as she filled your glass. I was much impressed by this courtesy. There were never less than three wines. These loosened the tongue but did not cause one to stagger from the table. Coffee and liquors were served in the living room and the gentlemen were offered excellent Dutch cigars. Music, cards and billiards were available. The crowd enjoyed the conversation; their English was better than our faltering French.

*(To Be Continued in September Issue)*

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# Thromboembolism in Patients With Major Amputations*

A. N. PAPAIOANNOU, M. D.

DESPITE the striking reduction in mortality rate following surgical procedures that has followed improvement in anesthesia, the introduction of antibiotics, and better understanding of homeostasis, there has been no reduction in the mortality rate from thromboembolism. On the contrary, some reports[1,2] suggest an increase in the absolute number of deaths from thromboembolism.

It was decided to undertake a study of this problem in a group of patients exposed to special risk. For this purpose, patients undergoing major amputation for ischemic necrosis due to arteriosclerosis (arteriosclerotic gangrene) were selected because they present a combination of local and general factors particularly favorable for the development of venous thrombosis and its sequalae. Indeed, Veal[3] and Edwards[4] have previously reported a high incidence of thromboembolism in such patients.

This study was carried out with the following objectives:

1. To determine the importance of thromboembolic complications in patients undergoing major amputations for arteriosclerotic gangrene.
2. To compare the incidence in two periods representative of the pre- and postantibiotic era.
3. To examine our experience in the treatment of this complication in this group.

## Material

Patients selected for this study were those admitted to the Cleveland Metropolitan General Hospital because of arteriosclerotic gangrene requiring amputation above the level of the foot.

Two groups of patients were arbitrarily selected. Each represents a four year period of consecutive admissions. The chronological gap between the two groups was made sufficiently large to demonstrate clearly the influence of antibiotics and other improvements in therapy in the latter period.

The first group included 113 patients admitted between 1938 and 1942. Two of these had major amputations on two separate occasions. The second group was composed of 165 patients admitted between 1952 and 1956. Eighteen of these had major amputations on two separate occasions. Bilateral amputations done at the same time have been considered as one.

The numerical increase in the 1952-56 group does not truly reflect the marked increase in the number of patients with arteriosclerotic gangrene treated in this hospital as, in the second period, a far greater

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proportion was treated conservatively by sympathectomy, arterial grafting, or minor amputation.

## Results

The age distribution in each group is shown in figure 1. This shows a trend toward an increasing preponderance of elderly patients. It is also noteworthy that this trend is confined to the nondiabetic patient and is not seen in diabetics.

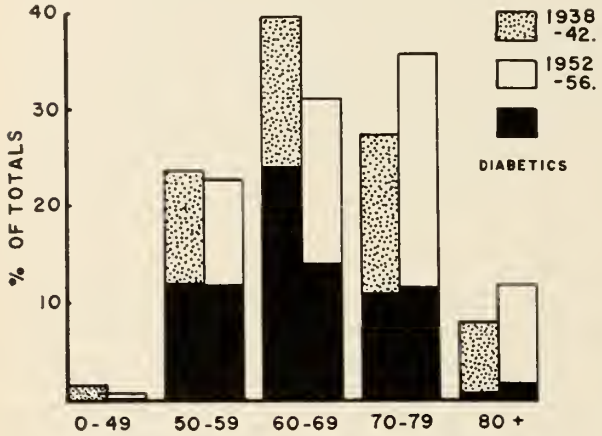



FIG. 1. *Distribution in Age Groups of Amputees with Proportion of Diabetics in Each Group*

The causes of death in each group are set out in figure 2. This demonstrates a marked reduction in all causes of death, except cerebrovascular accidents and pulmonary embolism, which both show a slight increase.

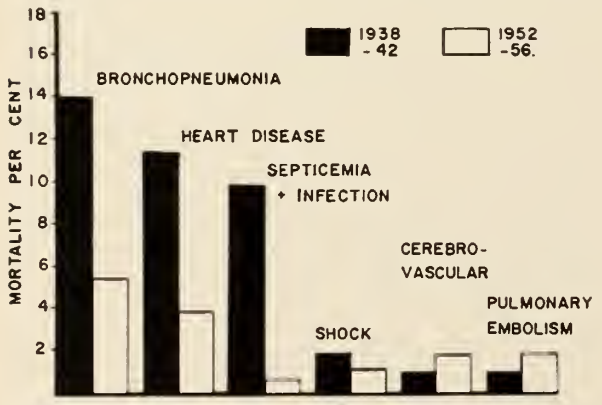



FIG. 2. *Distribution of Causes of Death Among Amputees*

The general mortality rates were 38.2 per cent for the 1938-42 group and 14 per cent for the 1952-56 group. These percentages are comparable with those reported by Veal[6] in 1935 (39.1 per cent) and Edwards[7] in 1952 (14 per cent).

The incidence of phlebitis and pulmonary embolism encountered in both groups of patients under study, is summarized in Table 1.

**Results of Therapy for Postoperative Thromboembolism.** Of 10 patients with clinical evidence of phlebitis, three developed embolic sequelae. Ten patients were treated by vein ligation, including one for prophylactic reasons. Anticoagulants were not used in these elderly patients with recent operative procedures. It is interesting to record the results in five of these patients treated by vein ligation who developed various sequelae.

CASE 1: This patient, subsequent to deep femoral vein ligation, developed edema of the stump and separation of the suture line.

CASE 2: This patient underwent inferior vena cava ligation for bilateral phlebitis with signs of pulmonary embolism. No further embolism occurred, but he developed edema with subsequent necrosis of the stump and gross edema of the contralateral leg, which did not subside for four years.

CASE 3: A common femoral and major saphenous vein ligation was performed but the patient died of pulmonary embolism three days later.

CASE 4: This patient died of pulmonary embolism 21 days after right common iliac vein ligation. At autopsy, thrombus was found to have formed proximal to the ligation.

CASE 5: A prophylactic superficial femoral vein interruption was carried out in this patient at the site of amputation. The patient died 20 days later. At autopsy, small pulmonary emboli and phlebitis of the contralateral leg were found. Pathological findings at the operative site were not reported.

## Discussion

There are many factors contributing to the development of venous thrombosis in this type of patient. Their age, debility, and a high incidence of associated heart disease are general predisposing factors, which have long been recognized to increase the incidence of thromboembolic phenomena. A multiplicity of local precipitating factors are added in these patients. Immobilization, surgical trauma, direct endothelial injury with a blind venous stump render the amputated, arteriosclerotic stump exceptionally liable to develop venous thrombosis. Furthermore, early ambulation and anticoagulant drugs are contraindicated in these elderly patients with recent operative wounds.

For these reasons, it was a surpise to find that the incidence of clinical phlebitis in these series was slight, notwithstanding the fact that the number of deaths from thromboembolism (.87 per cent in 1938-42 and 1.6 per cent in 1952-56) was higher than would be expected from collected hospital data (.05 per cent[8]).

It has been observed that the incidence of phlebitis varies widely in different institutions, possibly as a result of the differing degrees of interest and alertness to this problem. However, this may not be the explanation for the low incidence in this study for, in the latter period when widespread general attention has been focused on this complica-

TABLE 1. *Phlebitis and Pulmonary Embolism Detected in Patients Undergoing Major Amputations*

| Type of Evidence | Outcome | Patient Group 1938-42 (113 patients) | Patient Group 1952-56 (165 patients) |
|---|---|---|---|
| 1. *Clinical evidence* of phlebitis | | 3 | 7 |
| 2. *Clinical evidence* of pulmonary embolism | Fatal | 0 | 3 |
| | Nonfatal | 2 | 1 |
| 3. *Pathological evidence* of phlebitis (Venous thrombosis in main veins of amputated specimen.) | | 1:6 | 1:5 |
| 4. *Autopsy evidence* of pulmonary embolism | Fatal | 1 | 2 |
| | Nonfatal | 0 | 4 |

tion, no increase in the incidence of clinical phlebitis is noted.

It is possible that in this group of patients the scantiness of clinical manifestations of the disease may be due to the poor biological response which is frequently encountered. This type of quiet phlebothrombosis with few clinical signs is said also to be associated with delayed organization of the thrombus and increased liability to become detached and produce pulmonary embolism.[10]

The actual incidence of pulmonary embolism may have been considerably higher than appears from these data. Autopsy findings were not available in many of these patients. Pulmonary embolism is frequently misdiagnosed as myocardial infarction, pleurisy, etc. As Byrne emphasized, it is especially likely to be overlooked in patients with hemiplegia.[11]

Venous thrombosis found in the amputated specimen of our cases (1:5 in the 1938-42 group and 1:6 in the 1952-56 group) was also lower than in other reports (1:3 Edwards, 1950[4]). This is probably due to the fact that thrombosis was noted only in main venous channels.

Hunter, dissecting the calf muscles at autopsy, found a 52.7 per cent incidence of venous thrombosis,[12] a far higher proportion than has ever been noted clinically. Similarly, thrombosis is usually present in minute vessels at the site of gangrene.[10]

Our experience in treating phlebitis in this group of patients has been disappointing. Edema, a common sequel,[13,14] is likely to be particularly disadvantageous at the amputation site, as in Case 1 in which wound separation developed. Ligation of the inferior vena cava in Case 2 appeared to fulfill its primary purpose of protecting from further emboli. However, undesirable sequalae resulted in a long-lasting disability to this patient. The possibility of fatal pulmonary embolism following vein ligation is demonstrated by Cases 3 and 4.[13,14,15] Case 4 particularly shows that propagating thrombosis may develop proximal to the venous ligation.[16,3] Case 5, in which the left superficial femoral vein was prophylactically interrupted because of previous hemiplegia[11] showed pulmonary emboli at autopsy with phlebitis in the contralateral leg, indicating that bilateral ligation is necessary, if the procedure is considered to be worthwhile.[17,4,3]

An additional observation deserves mention. In most of our cases, phlebitis developed on the amputated site. This is in keeping with our previous suggestion that retardation of the blood flow with stagnation in the blind venous stump and direct endothelial injury are likely to promote an increased incidence of venous thrombosis in patients undergoing major amputation.

## Summary

1. A review of the problem of thromboembolism in patients undergoing major amputation for arteriosclerotic gangrene at the Cleveland Metropolitan General Hospital has been undertaken.

2. It was shown that, although the overall mortality has markedly improved, deaths from thromboembolism show no reduction.

3. Our experience in the treatment of this complication in this group of patients is discussed.

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# Aldosteronism and Hypertension

JACK H. MOSTOW, M.D.

ALDOSTERONE has been implicated increasingly in recent years as an etiologic factor in hypertension. In primary aldosteronism (Conn's syndrome) this etiologic relationship is most striking and represents a *correctable* form of hypertension deserving of intensive investigation when even a slight possibility of the entity exists. In malignant, primary (benign essential), and renal hypertension, the role of aldosterone has not been as clearly defined, but there is much experimental and clinical evidence to support an inter-relationship of aldosteronism with these as with other forms of hypertension.

An attempt will be made in this paper to summarize the current status of aldosteronism and hypertension, with a review both of experimental and clinical data. Primary emphasis in this discussion will be on primary aldosteronism, a *correctable* form of hypertension.

## I. Aldosterone (Characterization, Measurement, And Control Mechanisms)

Aldosterone, the 18-aldehyde of corticosterone, has a potency 10 to 30 times that of desoxycorticosterone acetate (Doca®) and greater than all other mineralocorticoids. Normal subjects secrete about 25 mg. per day of hydrocortisone and only 250 micrograms of aldosterone. Utilizing paper chromatographic techniques, the normal range of 24 hour urinary excretion of aldosterone is 0-15 micrograms. The isotope dilution technique as utilized by Ulick and others[1] involves the injection of a trace amount of aldosterone tagged with tritium, and the determination of the specific activity of a urinary metabolite of aldosterone in the subsequent 24 hour urine. Normal aldosterone secretion rate ranges from 150-330 micrograms per day. It should be noted that normal subjects will increase their aldosterone secretory rate to about 1000 micrograms per day in response to sodium deprivation, and that feeding of large amounts of sodium reduces the rate to as low as 50 micrograms per day.

Concerning control mechanisms for aldosterone secretion, three factors should be considered: (1) adrenocorticotropic hormone (ACTH) and "glomerulotropin"; (2) plasma potassium level; and (3) blood volume changes.[2,3,4] To a large degree, aldosterone production is independent of ACTH; however, ACTH will produce a significant, if transient, rise in aldosterone excretion. After hypophysectomy, aldosterone output is significantly reduced but to a much lesser extent than the other corticoids. Farrell et al. indicate that an extract from the region of the pineal and subcommissural body, "glomerulotropin,"[4] causes an increase in adrenal venous aldosterone. Regarding plasma potassium changes, it recently has been shown that both the inhibiting effects of potassium deprivation and the stimulating effect of potassium administration on aldosterone secretion can occur independently of changes in body-fluid volume and overall sodium balance. Concerning blood volume changes, Bartter et al.[3] have demonstrated that contraction of the extracellular fluid volumes, and, more specifically, of the intravascular volume, is accompanied by an increase in aldosterone excretion. Recent work suggests that localized and definitive pressure changes within the vascular tree, which are not necessarily related to overall volume changes, might be an important stimulus for aldosterone secretion.

Submitted December 26, 1961.

### *The Author*

● Dr. Mostow, Akron, was Research Fellow and Clinical Instructor, Department of Medicine, Division of Endocrinology and Metabolism, Ohio State University Hospital, during preparation of this article. Now associated with The Akron Clinic, Akron, Ohio.

## II. Experimental Hypertension

Two different types of experimental hypertension associated with increased amounts of adrenal steroids have been produced in animals, namely: mineralocorticoid and glucocorticoid. Mineralocorticoid hypertension was first produced in rats after desoxycorticosterone acetate administration by Selye.[5] This hypertensive state is a malignant one characterized by widespread vascular damage, sodium retention, potassium depletion, and extracellular alkalosis. The hypertension and electrolyte abnormalities depend on adequate amounts of sodium in the diet. A similar state of hypertension has been produced with aldosterone.[6] The hypertensive state following Doca and

salt administration becomes irreversible after a time, so that it continues unabated despite withdrawal of both steroid and salt, so-called metacorticoid hypertension. Glucocorticoid hypertension has been produced in rats following the administration of a number of steroids including cortisone, hydrocortisone, and corticosterone. This hypertension is not affected by the amount of sodium in the diet or by uninephrectomy, and is not accompanied by extracellular alkalosis. Natriuretic agents will not improve it, but they will improve the mineralocorticoid type.

Goldblatt[7] demonstrated that adrenalectomy interferes with the production of renal hypertension caused by constriction of the renal arteries, a finding supported by others. Whether the adrenal cortex is involved in the pathogenesis or merely plays a permissive role is difficult to determine. If the experimental renal injury is extensive, hypertension will appear or persist even in the absence of the adrenals.

Deane and Masson[8] in 1951 found that injection of renin or the production of renal hypertension produced hypertrophy of the glomerulosa zone of the adrenal cortex, the site of aldosterone production. A renal-adrenal interplay was proposed and has been subsequently supported by a number of studies. In rats and dogs a parallel relation between the width of the adrenal zona glomerulosa secreting aldosterone and the granularity of the renal juxtaglomerular cells elaborating renin or a renin-like substance, in response to changes in blood pressure, and in sodium or potassium intake, has been shown. Experimental evidence suggests that hyperfunction of the adrenal zona glomerulosa is accompanied by increased granularity of the juxtaglomerular cells and renin content of the kidneys. Gross[6] and others demonstrated that the renin content of normal rat kidneys is reduced by Doca or by aldosterone administration, when sodium is provided in the diet, and that renin content is increased in adrenalectomy.

Gross, because of his findings, has also proposed that renin may stimulate, directly or indirectly, the secretion rate of aldosterone. He found that the capacity of aldosterone to produce hypertension and vascular lesions is relatively less than that of Doca when both corticoids are administered in the same way. By varying the sodium uptake, he demonstrated changes in the content of renin in the kidney in the same direction as the secretion of aldosterone. There was an inverse relationship between the renin concentration in the kidney and the sodium content of the organism. It was suggested by Gross that renin is involved in the pathogenesis of experimental hypertension not on the basis of its direct activity on blood pressure, but because it is involved in sodium metabolism.

It is of interest that, in rats prepared by the administration of mineralocorticoid and salt, an "eclampsia-like" syndrome is produced by the administration of renin. This is characterized by severe vascular damage, marked anasarca, and death and does not occur in normal animals given renin.[9]

### III. Pathogenesis of Hypertension in Humans, And the Specific Role of Aldosterone

Genest et al.[10] have demonstrated definite abnormalities in urinary aldosterone, pregnanetriol, and pregnanetriol/aldosterone ratio in patients with benign or severe essential hypertension and in patients with renal and malignant hypertension. Angiotensin-II infusions stimulated specifically aldosterone both in normal and in hypertensive subjects. Whereas an increase in aldosterone during angiotensin infusions is accompanied by significant sodium retention and lowering of the urinary sodium/potassium ratio in normal subjects, urinary sodium and sodium/potassium ratio increased markedly in patients with benign essential hypertension. No explanation is offered for this phenomenon. Angiotensin has also been demonstrated in the blood of some hypertensive patients.

Genest found an excretion of aldosterone above normal in 43 per cent of patients with essential hypertension; an excessive fluctuation in daily urinary aldosterone in patients with arterial hypertension, especially in the early phase of the disease, as compared to normal subjects similarly studied; a mean decrease in urinary pregnanetriol in patients with essential, renal, and malignant hypertension as compared to that of normal subjects; a highly significant decrease in pregnanetriol/aldosterone ratio in 92 per cent of all hypertensive patients studied; a significant hypotensive effect of progesterone in seven patients with arterial hypertension; and most important, a marked and specific trophic effect of valine$_5$-angiotensin II on urinary aldosterone excretion. Genest's studies provide direct evidence of a correlation between the adrenal zona glomerulosa secreting aldosterone, sodium regulation, and the renal juxtaglomerular apparatus responsible for elaboration of renin or of a renin-like substance. The stimulatory effect of angiotensin on aldosterone appears quite marked and specific, as such an effect was noted only once in seven experiments with norepinephrine, and not with Neo-Synephrine®. Studies currently are underway in Genest's laboratory to do simultaneous determinations of blood angiotensin, urinary aldosterone, pregnanetriol, and pregnanetriol/aldosterone ratio in hypertensive patients.

Laragh[11,12] questions Genest's results in patients with essential hypertension. He has found that, when adrenal secretion rate of aldosterone was measured by a more precise technique of isotope dilution in a group of patients with typical uncomplicated benign essential hypertension under conditions of controlled metabolic balance, the values were entirely within normal limits. He feels that, while aldosterone does not participate in the pathogenesis of essential hypertension, increased aldosterone secretion may be encountered inconsistently as these patients develop renal and/or cardiac complications.

Genest, taking account of the differences in Laragh's

findings, cites the necessity of doing serial aldosterone secretion rate determinations. He questions the validity of the isotope dilution method on the grounds that if one measures the labelled tetrahydro derivative of aldosterone in urine, it cannot be totally independent of the rate of degradation of aldosterone into its tetrahydro derivative.

Reubi and Dahl[13] pose the question that if excess aldosterone production is primary in hypertension, one would expect a correlation between the amounts produced and hypertension; however, patients with primary aldosteronism frequently have relatively mild hypertension, and, among cirrhotic and certain cardiac patients who may produce greatly increased amounts of aldosterone, hypertension is notable by its absence.

Venning and Dyrenfurth[14] found that although the majority of patients with benign essential hypertension excrete amounts of aldosterone within normal range, the mean excretion of 26 patients was significantly higher than that observed in normotensive individuals. The mean excretion of the tetrahydro metabolite of aldosterone was also found to be higher in patients with essential hypertension. Their studies suggest that aldosterone may play some role in the etiology of essential hypertension, but a direct causal relation seems unlikely.

Laragh has found, as did Genest, that angiotensin consistently produces an increase of aldosterone secretion. This was in contrast to the effect of catecholamines. His results suggest that aldosterone may regulate salt balance and blood pressure by its interaction with pressor substances such as angiotensin. He also found that epinephrine, norepinephrine, and related agents may cause a sharp decline in secretion rate of aldosterone in sodium-depleted subjects who have hypersecretion of aldosterone, but, in subjects on normal sodium intake, this effect is usually absent. It has been suggested that the influence of the catecholamines is indirect. Their action may provide an explanation for the beneficial effect of sympathomimetic agents in certain patients with edema. Laragh's experiments show that aldosterone hypersecretion can be suppressed by pressor agents despite an induced natriuresis, a declining body weight, and presumably a further contraction of intravascular volume. His results suggest it is perhaps unnecessary to postulate a volume-oriented system to explain changes in aldosterone secretion. The observed changes could thus be the result of induced pressure changes mediated through known pressoreceptors. Laragh has also noted that unlike norepinephrine, angiotensin may cause an increase in venous pressure, a situation which may stimulate aldosterone secretion.

## IV. Aldosterone and Hypertensive Vascular Disease

The following outline[12] may serve as a guide to consideration of the relationship of aldosterone secretion to hypertensive vascular disease:

1. Hypertensive disease caused by aldosterone hypersecretion of an adrenal adenoma (Primary aldosteronism; Conn's syndrome)

2. Hypertensive disease associated with bilateral adrenal hypersecretion of aldosterone (without adrenal tumor)

   *a.* Malignant (accelerated) hypertension

   *b.* Severe or malignant hypertension due to unilateral renal disease

   *c.* Severe or malignant hypertension possibly due to congenital adrenal hyperplasia

3. Hypertensive disorders which are inconsistently or possibly associated with aldosterone hypersecretion

   *a.* Primary (benign essential) hypertension(?)

   *b.* Primary hypertension complicated by renal or cardiac failure

   *c.* Chronic renal disease (pyelonephritis or glomerulonephritis)

   *d.* Adrenal carcinoma with increased aldosterone secretion

In malignant hypertension, marked hypersecretion of aldosterone almost invariably occurs with the abnormal secretory rate values ranging from 510 to 10,000 micrograms per day. Furthermore, unlike normal subjects, the secretory rate is not suppressed by the administration of sodium salt. It is more likely that aldosterone hypersecretion is a secondary rather than a primary event in malignant hypertension because (a) the clinical syndrome differs from that of primary aldosteronism due to adenoma, (b) adrenal tumors are characteristically absent, suggesting an extra-adrenal stimulus, (c) the disorder is not usually corrected by adrenalectomy, and (d) hypersecretion of aldosterone is absent in most forms of hypertension and becomes more apparent as patients develop complications. However, even if not primary to the hypertensive state, aldosterone hypersecretion may play a significant role in causing or sustaining the malignant syndrome. Renal damage is always present in malignant hypertension, and it is possible that renin release, generating angiotensin, causes the aldosterone hypersecretion.

In malignant hypertension, aldosterone hypersecretion is possibly secondary to impaired renal circulation and the release of a pressor substance which stimulates aldosterone release. A clinical picture of severe accelerated hypertension with necrotizing arteriolitis results. In this regard, experiments demonstrate that mineralocorticoid, when combined with renin administration, produces more severe vascular damage.

Laragh suggests that the approach to malignant hypertension should be steered toward measures to define and correct abnormalities in renal circulation. Included in treatment might be the feeding of added

salt to attempt to improve the renal circulation (and thus suppress renin and aldosterone).

In malignant hypertension, the frequent occurrence of hypokalemic alkalosis as manifested by an elevated plasma bicarbonate and/or a reduced plasma potassium concentration in patients with advanced or with malignant hypertension appears as a somewhat unexpected finding. This tendency to alkalosis may be taken as supportive evidence for increased aldosterone secretion. The alkalosis may have additional significance since it was found to occur at times in the presence of renal failure, where retention of fixed anions ordinarily tends to lower the plasma bicarbonate level, and thus could mask the typical plasma abnormalities of aldosteronism. Hypernatremia is consistently absent and hyponatremia is common, a finding which does not occur in primary aldosteronism. Conn[15] considers this absence of hypernatremia a very important point of differential diagnosis of primary aldosteronism, wherein may reside the explanation for the secondary aldosteronism which occurs in some patients with hypertensive disease. In malignant hypertension, increased secretion of aldosterone seems to be due to bilateral adrenal hyperfunction rather than to an adrenal adenoma. If aldosterone is important in the pathogenesis of malignant hypertension, one might expect beneficial effects from bilateral adrenalectomy; however, results of adrenalectomy have been variable.

In studying unilateral renal disease with severe or malignant hypertension, Laragh noted decreased serum potassium in six patients, two of whom had markedly elevated aldosterone. After nephrectomy, aldosterone decreased to normal levels with improvement of the clinical picture. Goldblatt in his original work stressed that both renal arteries must be constricted in order to produce sustained severe hypertension. It seems clear that a certain per cent of patients with unilateral renal disease do exhibit malignant hypertension and may represent another expression in man of Goldblatt hypertension with renal ischemia leading to release of renin and, as a result, increased aldosterone secretion.

A small number of cases of severe hypertension, often with papilledema, associated with aldosteronism, have been reported in which some improvement or cure has followed partial or total adrenalectomy. The adrenal glands do not contain tumor and appear either normal or hyperplastic. Conn[15] considers this group of patients a special form of congenital adrenal hyperplasia. He believes a long history of polyuria may be a differential clinical sign.

Concerning the role of aldosterone in essential hypertension, the current controversy between Genest and Laragh has been discussed earlier. One case of adrenal carcinoma with increased aldosterone secretion is reported, but this hypertension could be caused by other steroids. In Cushing's syndrome with hypertension, aldosterone secretion is usually normal. Elevated aldosterone levels have also been reported in chronic renal disease, both in pyelonephritis and glomerulonephritis.

## V. Primary Aldosteronism

### *A.* General Discussion.

Primary aldosteronism has been found with greater frequency in women than in men, with the peak age incidence between 30 and 49 years of age. Conn,[15] reporting his analysis of 108 cases of aldosteroma, found the disease was two and a half times more common in women than men and that 70 per cent of cases were in the 30-49 age group. In most cases it is caused by an adrenal adenoma, though in young patients adrenal hyperplasia may be more frequent. It is the exact counterpart metabolically of the syndrome which was produced in dogs and in rats given excess amounts of desoxycorticosterone acetate, the cardinal abnormality being the tendency to renal potassium wastage in the presence of gross body depletion and the tendency to resist potassium repletion. Thus, the administration of potassium supplements stimulates aldosterone production, which in turn promotes more kaliuria. Aldosterone and Doca facilitate potassium loss presumably by increasing sodium absorption. This concept necessitates the presence of sodium ions at the site of cation exchange in order for potassium to be secreted. The corollaries are that Doca and aldosterone will not induce potassium loss in subjects placed on a low sodium diet or, contrariwise, that the administration of sodium under such circumstances (i. e., aldosteronism) facilitates potassium loss.

The relation of pyelonephritis to the potassium-depleted kidney is important. The renal tissue of the potassium-deficient subject is particularly susceptible to damage, and the incidence of pyelonephritis is greater in aldosteronism than in other forms of potassium depletion. In the large series reported by Conn[15] removal of the aldosteroma resulted in correction of the hypernatremic hypokalemic alkalosis in all cases. In 66 per cent of cases, the hypertension was cured; in 20 per cent it was improved. It was considered likely that the remaining patients developed renal hypertension secondarily, probably on the basis of kaliopenic nephropathy, nephrosclerosis, pyelonephritis, or a combination of the three. This sequence of events is probably the operative mechanism as well in experimental metacorticoid hypertension, in which persistent hypertension is noted following cessation of a long period of treatment with Doca.

### *B.* Signs and Symptoms.

The signs and symptoms of primary aldosteronism may include the following:

1. Intermittent tetany (tetanic crises) (in the presence of normal serum calcium, alkalosis and low serum magnesium may be factors)
2. Paresthesias

*(Continued on Next Page)*

3. Periodic severe muscular weakness and flaccid paralysis (explained by low serum potassium)

4. Polydipsia, polyuria, nocturia (polyuria related to hypokalemic nephropathy, results from impaired ability of kidney to produce an osmotically concentrated urine)

5. Hypertension, usually mild (indistinguishable from "essential" type; hypertensive retinopathy frequent; occasional malignant hypertension)

6. No edema (but this has been observed)

7. Severe headaches

8. Muscle cramps and pains

9. Positive Chvostek and Trousseau signs

10. Cardiac enlargement

*C.* **Laboratory Findings.**

The laboratory findings in primary aldosteronism are summarized as follows:

1. *Increase in urinary aldosterone or in aldosterone secretion rate.* (May be normal at certain times during the course of the illness.)

2. *Hypokalemia and negative potassium balance.* (Hypokalemia is *the most constant laboratory finding,* and may or may not be accompanied by hypernatremia and alkalosis; EKG may reveal low T-waves, U-waves.)

3. *Hypernatremia* (with poor response to potassium feeding).

4. *Extracellular alkalosis.* (This is induced by potassium depletion; intracellular acidosis also occurs, resulting from a shift of hydrogen ions into cells in exchange for the lost cellular potassium.)

5. *Low specific gravity urine* (which does not respond to Pitressin® or to fluid deprivation; urine alkaline or neutral with inability to respond normally to an ammonium chloride load).

6. *Low sodium, high potassium* in urine, sweat, saliva, stool.

7. *Low plasma magnesium* (in some cases).

8. *Persistent or intermittent albuminuria.*

9. *High urinary potassium/plasma potassium ratio* (at low serum levels of potassium).

10. *Impaired carbohydrate tolerance* (occasionally).

*D.* **Differential Diagnosis.**

The following disease entities require consideration in the differential diagnosis of primary aldosteronism:

1. "Potassium-losing" nephritis

2. Renal tubular acidosis (excluded by presence of extracellular alkalosis)

3. Familial paralysis

4. Diabetes insipidus

5. Hypokalemic alkalosis of other origin

6. Sodium-losing renal disease with compensatory hyperaldosteronism ("salt-losing nephritis"). This is more difficult to exclude and may require the demonstration of normal renal sodium conservation on a low sodium dietary regimen. Bartter[16] feels that "salt-losing nephritis" constitutes the greatest problem in differential diagnosis. Here, obligatory renal sodium loss may lead to secondary increases in aldosterone secretion, leading to alkalosis, hypokalemia, potassium depletion, loss of concentrating ability, and finally, hypernatremia, exactly as with primary aldosteronism. Bartter states that the response to the use of a very low sodium diet provides not only a valuable adjunct to treatment but also the most useful available information with regard to differential diagnosis. With a low sodium diet, the following occurs: (1) patients with both primary and secondary aldosteronism are enabled to retain potassium much better than they can with high sodium diets; (2) those with primary aldosteronism and little or no renal damage may immediately demonstrate the ability to lower urinary sodium virtually to zero, thus ruling out a primary tubular sodium losing lesion; and (3) patients with primary aldosteronism and considerable renal damage, who have lost the capacity for renal sodium conservation, may demonstrate a return of this aspect of renal function after restoration of the potassium deficit.

Additional measurements useful in differentiating primary aldosteronism have been reported by Biglieri, et al.[17] to include (a) an expanded and fixed extracellular fluid, total blood volume, and plasma volume in conjunction with normal red cell volume, and (b) the use of an aldosterone antagonist, spironolactone (Aldactone®) as a differential test of increased aldosterone secretion. The effects of spironolactone (1 gram in four divided doses given daily for three days) in five patients with primary aldosteronism were transient correction of the hypokalemia (increases of greater than 1.2 mEq./liter of potassium in each patient), marked natriuresis, decreased urinary potassium level, and increased urinary aldosterone (probably due to the natriuresis). Based on the demonstrable changes observed with the use of spironolactone, it has recently been considered advisable to prepare patients with primary aldosteronism with several weeks of spironolactone therapy prior to surgery in an effort to decrease the operative risk due to hypokalemia and hypertension.

*E.* **Conclusion.**

Since an arterial hypertension clinically indistinguishable from essential hypertension may be the sole manifestation of primary aldosteronism, serum potassium determinations should be carried out in *every* hypertensive patient, whatever his age. It should be remembered always that primary aldosteronism is a potentially *curable* disease.

## VI. Summary

Aldosterone, the most potent of mineralocorticoids, has been shown increasingly in recent years to have etiologic importance in many types of hypertension, but most strikingly in primary aldosteronism (Conn's

syndrome). Experimental evidence supports an interrelationship between the adrenal zona glomerulosa, which secretes aldosterone, and the renal juxtaglomerular cells elaborating renin or a renin-like substance, in response to changes in blood pressure or variations in sodium or potassium intake. In humans, infusions of angiotensin have consistently produced an increase in aldosterone secretion both in normal and in hypertensive subjects.

Marked hypersecretion of aldosterone almost invariably occurs in malignant hypertension, with most evidence suggesting this is a secondary rather than primary event. Inconsistent elevations of aldosterone are reported in essential hypertension.

Primary aldosteronism, in most cases due to an adrenal adenoma, is a potentially *curable* form of hypertension. The signs and symptoms include intermittent tetany, paresthesias, muscular weakness, polydipsia, polyuria, nocturia, mild hypertension, headaches, muscle cramps, and cardiomegaly. Laboratory findings include increased urinary aldosterone, hypokalemia with negative potassium balance, hypernatremia, extracellular alkalosis, urine of low specific gravity unresponsive to Pitressin or fluid deprivation, low plasma magnesium, and low sodium, high potassium in urine, sweat, saliva, and stool. To establish the diagnosis, it may be of further value to study (1) the effect of severe sodium restriction, (2) the effect of an aldosterone antagonist (spironolactone) for several days, and (3) the demonstration of increased total blood volume due to increased plasma volume in the presence of a normal red cell volume. Since primary aldosteronism is potentially curable, the level of serum potassium should be determined in *every* hypertensive patient, regardless of age.

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STEROIDS IN ASTHMA. — A retrospective survey was made of 135 patients who, after failing to respond to other therapy, were treated for up to 8 years with steroids at the asthma clinic of the University College Hospital in London. The aim was to try to determine whether steroid therapy for asthma is likely to have to be permanent and which type of patient (if any) is likely to be weanable from these drugs. It was found that while quite long periods off treatment are possible (25 remissions were longer than a year), there was no way of predicting which type of case will have long remissions.

The group of 135 patients included 119 true asthmatics, six patients with asthma associated with hay fever, and 10 who may have been suffering primarily from bronchitis. Approximately 55 per cent of the true asthmatics had stayed on steroids continuously at doses approximating 2.5 to 20 mg./day of prednisone. The other 45 per cent were primarily weaned from steroids at the expense of some discomfort and showed a significant tendency to require treatment continuously. The need for long-term therapy was especially noticeable in patients whose asthma had developed after the age of 30 years. Patients most easily weaned from therapy were the six whose asthma was associated with hay fever and the 10 who were possibly suffering from chronic bronchitis; these latter patients did not respond initially but later responded to larger doses. — ABSTRACT: J. P. Knowles, London, Eng.: *British Medical Journal,* II:1396-1399 (November 25) 1961.

# Enzyme Shock

A. T. ANTON, M.D.

THIS REPORT describes the clinical course of a patient who developed terminal shock of obscure etiology. The clinical evidence suggested it may have been induced enzymatically by the pharmacological actions of a monamine oxidase inhibitor.

Protein metabolism involves complex transformations of different amines, and only a few pathways of metabolism are common to all amino acids. In most instances the changes through which an amino acid progresses are peculiar to that acid alone. In order to explain this metabolism, it is necessary to postulate the action of a number of specific enzymes, which have the capacity of influencing the fate of any amino acid. One of the catabolic processes results in their deamination through oxidation, by means of a monamine oxidase (MAO) enzyme system. The distribution of this enzyme has been demonstrated in animal tissues of the liver, kidneys, interstitial mucosa, lung, hypothalamus, central grey matter of the brain, and blood vessels.[1]

The stimulus for a re-study of this system, which had originated in 1928, culminated from observations that iproniazid, used as an anti-tuberculous agent, possessed psycho-pharmacological properties.[2] Subsequently, a number of other hydrazine compounds were found to possess similar properties.[3] One of the common properties displayed by this group of compounds is the inhibition of the monamine oxidase enzyme system, which is concerned with the catabolism of many amines but with that of serotonin and norepinephrine principally. As a result, there is an accumulation of these amines in tissue and blood. Their psycho-pharmacopedics and physiological consequences have been, and continue to be, the target of volumes of research.

## Case Report

The patient was a 38 year old white woman who died 48 hours after hospital admission. She was first examined in February 1960 because of a mild cough productive of scant mucoid sputum, orthopnea, and recurrent pain in the left arm associated with numbness in both hands. She was unaware of any provocative factors associated with exertion, emotion, or position. The past history revealed that 13 years previously she had experienced a postpartum psychosis. Twelve years previously she had a bilateral tubal ligation. In previous years, she was told that she had high blood pressure.

The results of subsequent examinations and study were consistent with the diagnosis of essential hypertension associated with moderate left ventricular hypertrophy (blood pressure 220/120) and moderate nutritional obesity (height five feet, weight 180 pounds). Provocative home factors contributed to major episodes of grief and frustration. Results of laboratory studies confirmed the clinical findings (Table 1). There was a significant and satisfactory response in symptoms and in blood pressure levels following the institution of therapy with reserpine and hydrochlorothiazide. Repeated blood pressure levels at 140/90 were obtained. She failed to maintain follow-up examinations for the next 10 months and discontinued drug therapy as well as dietary program for weight reduction during this period.

In February of 1961, she returned complaining of increasing dyspnea on effort for about a month. The abnormal physical findings had not changed appreciably from the previous examination, and blood pressure was again recorded at 220/120 in both arms.

The antihypertensive therapy was reinstituted. However, she developed progressive signs and symptoms of congestive heart failure with pulmonary edema and peripheral edema. This improved with the addition of digitalis and intensification of diuretic therapy. Blood pressure levels remained at 170/100 to 190/110. Following withdrawal of reserpine, treatment with a monamine oxidase (MAO) inhibitor (Marplan®) was initiated at 10 mg. daily and was subsequently increased to 30 mg. daily. During three weeks of therapy, the blood pressure levels ranged from 140/80 to 180/100. After three weeks the standing blood pressure was found to be 110/70. There were no signs of congestive heart failure, but she continued to complain of dyspnea on effort. Treatment with digitoxin 0.2 mg. daily, trichlormethiazide 4 mg. twice daily, Marplan 10 mg. three times a day, and moderate salt restriction (salt was not used at the table) was maintained. She developed a tendency to drowsiness and a significant loss of affect.

She was not seen again for three weeks. Two days before

TABLE 1.

| | |
|---|---|
| Hemoglobin | 15 Gm./100 ml. |
| Hematocrit | 41% |
| Fasting blood sugar | 93 mg./100 ml. |
| Serum Cholesterol | 186 mg./100 ml. |
| Blood Urea Nitrogen | 15 mg./100 ml. |
| Electrocardiogram | Primary T-Wave changes with low voltage limb leads, and inverted T-Waves in V5, 6, and 8. |
| Chest X-Ray | Clear lung fields, heart diameter 15 cm. Chest diameter 26 cm. |
| Intravenous Pyelogram | Prompt excretion of dye. Normal size kidneys. No ureteral obstruction. A small calculus in calyx of the left kidney. |

Submitted November 6, 1961.

## *The Author*

● **Dr. Anton, Springfield, Ohio, is a member of the active staffs of Mercy Hospital and Springfield City Hospital.**

her hospital admission, she complained of being cold and nauseated. She developed a menstrual flow, and noticed her urine was red. Her family noted that she was pale and sweating. Twenty-four hours later, with symptoms persisting, she developed hematemesis, and returned home, a trip of over 100 miles.

Physical examination at this time revealed an acutely ill woman, who had the cadavaric appearance of peripheral vascular collapse. The skin was pale and moist, there was pilo-erection, and the lips and nail beds were cyanotic. Supine blood pressure in both arms was recorded 150/92 and pulse 78. Pulses were palpable at all arterial loci. The pupils were dilated, equal, and reacted to light stimulation. There were no retinal changes. The caliber of the arteries was extremely narrow. Vein calibers were not unusual. Examination of the lungs revealed vesicular breath sounds and freely moving diaphram. The heart was enlarged to the anterior axillary line. The aortic second sound was greater than the pulmonic. The rhythm was regular, and there were no murmurs. Pelvic examination disclosed no diagnostic findings other than active uterine bleeding, and the remainder of the examination was not remarkable.

There were moments when she became extremely restless and thrashed about in bed. This intervened with moments of drowsiness, but she could be aroused and could carry on

TABLE 2.

| | | |
|---|---|---|
| Hemoglobin | 17 Gm./100 ml. | |
| Hematocrit | 49% | |
| Reticulocyte count | 0.2% | |
| White Blood Cell Count | 21,000 cells/cm. | |
| | P. 84% | L. 16% |
| Platelet Count | 414,000/cu. mm. | |
| Clot Retraction | Complete in 1 hr. and 40 min. | |
| Blood urea nitrogen | 35 mg./100 ml. | |
| Total Serum Protein | 6.58 Gm./100 ml. | |
| | Alb. | 4.56 |
| | Glob. | 2.02 |
| Prothrombin Time | 100% of normal | |
| Serum: Na+ | 137 mEq/L | |
| K+ | 4.4 mEq/L | |
| Cl− | 102 mEq/L | |
| Ca+ | 4.5 mEq/L | |
| $CO_2$ | 22.7 mEq/L | |
| Serum Bilirubin | Direct 1 mg./100 ml. | |
| | Total 2.2 mg./100 ml. | |
| S.G.O.T. | 140 units | |
| Urinalysis | Sp. Gr. | 1.021 |
| | Alb. | 15 mg./100 ml. |
| | Sugar | Negative |
| | W.B.C. | 3/h.p.f. |
| | R.B.C. | 100/h.p.f. |
| Upper Gastrointestinal X-Ray series (Hampton Technique) | No sign of ulcer or disease in stomach or duodenum. | |

a conversation. The etiology of the shock-like appearance remained uncertain. Urinary output was present and was supported with the use of intravenous fluids. About four hours after admission, the radial pulses were not palpable, but the apical pulse was forceful with the rate of 76 a minute. Brachial blood pressure readings became unobtainable, while pulses in the femoral arteries and carotid arteries were forceful. The heart sounds were distinct. During this interval the blood pressure fluctuated to a level of 100/90. Laboratory studies obtained in this hospital period are recorded in Table 2.

## Observations

When the blood pressure dropped to shock level, 5 mg. of metaraminol (Aramine®) was injected intravenously. There was a dramatic response. The blood pressure increased progressively to 240/110 and then declined in a half hour to 180/90. She developed extreme apprehension associated with pulsatile pounding in the chest. The peripheral pulse rate decreased to 50 per minute, but there was a precordial rate of 100. The electrocardiogram revealed two to one atrioventricular block with a ventricular rate of 50. Atropine gr. 1/150 was administered intravenously, and the peripheral pulse rate increased to 120 per minute. The blood pressure continued elevated for several hours. Through the next several hours, she developed recurrent episodes of a flushed appearance associated with abdominal cramping and bloody diarrhea.

During these episodes, there was a hypertensive crisis with levels recorded at 220/100 and pulse 68. Eight hours later the blood pressure was not obtainable and the radial pulses were not palpable but a loud apical beat could be heard. The apical pulse increased to 100, and the skin developed the appearance of livedo reticularis. The tongue became lavender in color, and the coolness and the sweating of the skin persisted. She was disoriented. She did not recover from this shock. Although pulmonary aeration appeared to be adequate, this contrasted strikingly with the cyanotic appearance of the mucus membranes. She was given intermittent positive pressure inspiration at 20 mm. of water, for 5 minutes, but there was no change in the color of the mucus membranes, nail beds, or blood pressure readings. During this interval an immediate dose of 2 mg. Aramine intravenously failed to elicit a blood pressure elevation and there was also failure of blood pressure to rise after the intravenous administration of diluted levarterenol. The skin changes intensified, and the vasopressors were discontinued.

During her course parenteral tetracycline and erythromycin were started empirically, and optimum doses of parenteral steroids were used. Urinary output was maintained with intravenous fluids of glucose in water and glucose in saline. In view of her failure to respond to concentrated doses of intravenously administered vasopressors, chlorpromazine 10 mg. was administered intravenously at hourly intervals, for two doses. There was an amelioration of the restlessness but there was no change in blood pressure response. During the next six hours coma supervened, this was followed by apnea and a preagonal convulsive seizure.

## Autopsy Findings

Autopsy was performed on the embalmed body 21 hours postmortem. The cause of death was not found. Significant findings were as follows:

Lungs: Congestion and edema were found in the lower lobes and there were scattered numerous small hemorrhages.

Heart: Focal hemorrhages were found in the epicardium; coronary arteries were patent; the right ventricle measured 0.5 mm. in thickness and the left 1.8 mm. The valves were not abnormal.

Liver: There was minimal central fatty dyscrasia.

Gastrointestinal Tract: There were mucosal and submucosal hemorrhages throughout the small intestine. There was no evidence of ulceration. The wall was thin and the lumen contained hemorrhagic fluid with congealed blood.

Spleen: There was a focal area of marked atherosclerosis with pinpoint narrowing in the splenic artery. The spleen contained a 3 cm. area of infarction in the periphery.

Adrenal Glands: Normal.

Kidneys: The cortex of the kidneys measured 8 mm. in thickness. Grossly they were normal. Microscopic examination revealed no significant abnormalities.

Urinary bladder: There was purulent cystitis with areas of ulceration and hemorrhage. (Indwelling catheter was removed before autopsy.)

Brain: Normal.

Vascular System: There were minimal atherosclerotic plaques in the abdominal aorta. (See Spleen.)

Reproductive Organs: Grossly, the myometrium was normal. The endometrium was dark and hemorrhagic. On section, there were areas of endometrial hemorrhage.

The remainder of the organs were reported to be normal.

## Discussion

The blood pressure levels on admission belied the shock-like appearance. The subsequent fluctuation of blood pressure to shock levels continued to be associated with peripheral signs of profound vasoconstriction, however the hypertensive crises were associated

with a flushing of the skin (vasodilatation) and diarrhea. The exclusion of primary gastrointestinal disease as the original problem seemed justified with the evidence available.

The subsequent display of fluctuations in blood pressure, and the vasomotor changes aroused the suspicion that the changes might be the result of chemically mediated responses. The peripheral signs were akin to the manifestations of increased circulating pressor amines. Although the pharmacological action of these amines are primarily pressor in function, an amphibaric response in the process of regulating vascular tone has been found to exist with certain amines (serotonin), under specific conditions.[4] This amine is also a powerful stimulant to smooth muscle. Shock, following paroxysms of hypertension associated with increased circulating amines, has been reported in numerous instances in humans.[5] The same phenomenon has been reported in laboratory studies. A reactive shock, or hypotensive response, follows the cessation of prolonged infusions of pressor amines in animals.[6] In these reports the pressor amines described were norepinephrine and epinephrine.[5, 6, 7]

It has been demonstrated, that monamine oxidase (MAO) inhibitors block the metabolic inactivation of circulating and tissue monamines. In many instances this oxidative deamination is the only pathway of metabolism.[8] In particular, this deamination process has been demonstrated to occur with 5-hydroxytryptamine (serotonin), tyramine, and epinephrine. The intermediate product of these reactions is an aldehyde, which is eventually excreted in the urine as its corresponding acid. The inhibition of monamine oxidase, then, is expected to result in increased levels of these pressor amines in the tissues and urine.

Investigations concerning the pharmacologic and clinical sequellae of these reactions have been the aim of many studies. As a result of these studies, a family of drugs has accumulated, the monamine oxidase inhibitors. These have been used in humans for the treatment of depressive states.[9] The observation that postural hypotension occurred uniformally as a side-effect created new avenues of study.[8] The mechanisms are related, in part, to ganglionic blockade.[10] The role which the hypothalamus might serve has been studied, but this needs further exploration. This center has been considered to be the most active site in the brain for serotonin metabolism, and it has been found to contain the greatest concentration of serotonin in the nervous system.[1] Unlike reserpine, which decreases the serotonin concentration in the hypothalamus, monamine oxidase inhibitors increase its concentration in the hypothalamus. However, serotonin does not cross the blood brain barrier. The results of such possible cumulative actions in this center are not clearly understood.

Toxicity due to hyper-noradrenalinemia is reported to be the consequence of toxic monamine oxidase inhibition, and the use of chlorpromazine has been described as a specific antidote to the pressor amines.[9, 11] A shock-like state accompanied by profound signs of peripheral vasoconstriction is similar to that described in patients developing shock associated with functioning pheochromocytoma.[4, 12] In this patient the adrenal medulla, where ordinarily 90 per cent of these tumors are to be found, was free of disease. The remaining 10 per cent are reported to occur in a variety of locations such as the paravertebral, thoracic, and lumbar spaces, the celiac ganglion, the area around the great vessels of the abdomen, and the cranial cavity. These areas were examined and found free of tumor. The only anatomical site not routinely explored was the neck, in the area of the carotid body and the jugular vein bulb. It is conceivable that an active tumor might have been located there. The punctuated, transient episodes of hypertension, peripheral vasodilatation, and diarrhea, are similar to the symptom complex induced by the hyper-serotoninemia of a functioning carcinoid tumor. Such a tumor was not found, but the anticipated rise of tissue and platelet serotonin levels secondary to monamine oxidase inhibition might bear further consideration.[4] The mechanism of the hemorrhagic diathesis remains unexplained except to indicate it occurred at the vascular-membrane border in the small intestine, urinary bladder, and uterus, and it was found in the lungs at autopsy. Whether or not the administration of phentolamine (Regitine®) in similar situations might serve beneficially remains an open question,[5] and might bear investigation.

## Summary

A case is presented suggesting that fatal shock associated with profound signs of vasoconstriction might have been enzymatically mediated by the use of a monamine oxidase inhibitor. Other drugs used in conjunction were a digitalis preparation and trichlormethiazide.

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# Hydroxyzine Hydrochloride* as a Premedicating Drug

A. BURTON PAYNE, M.D.; LEON G. CLAASSEN, M.D., and WILLIAM HAMELBERG, M.D.

DURING the first half of the twentieth century a series of drugs for premedication came into common usage. Their use has continued until the present. The narcotics produced psychic and metabolic depression but are associated with such disadvantages as respiratory depression, nausea, vomiting, dizziness, dysphoria, addiction, and cardiovascular instability. The belladonna drugs induce vagal and cerebral depression and decreased secretions, and they antagonize narcotic induced respiratory depression. However, they can lead to disorientation, tachycardia, and temperature elevation. The barbiturates provide hypnosis and are prophylactic against reactions from local anesthetic agents. These drugs thus provide adequate premedication but are associated all too frequently with undesirable side effects. Because of these side effects there continues a search for newer and better drugs. Such a drug, hydroxyzine hydrochloride (Atarax®), was used as part of the premedication routine in 1,004 patients.

## Chemistry and Pharmacology

Hydroxyzine hydrochloride is a piperazine derivative with a chemical formula of 1-(p-chlorobenzhydryl)-4-(2-[2-hydroxyethoxy]ethyl) diethylenediamino hydrochloride. It is not related chemically to the family of drugs commonly called tranquilizers.

The hydrochloride of hydroxyzine is a crystalline solid readily soluble in water and therefore is absorbed rapidly from the gastrointestinal tract. Its effect may be noted in 15 to 30 minutes after oral administration.

Toxicity studies have been carried out in mice where only central nervous system depression preceded death.[2] In rats tremor and ataxia accompanied this depression. Toxicity tests in rats indicated an LD-50 of 45 mg./Kg. intravenously.[3] Monkeys received up to 400 mg./Kg. orally and only emesis was noted.[2] To date no serious side effects or contraindications have been found after administration to humans.[4]

Hydroxyzine is thought to exert its activity upon some of the hypothalamic nuclei, the sympathetic portion of the autonomic nervous system and upon the reticular formation.[5] Its ataractic effect is obtained by influencing the neuropsychic or emotional balance of the individual, leaving one more indifferent to environmental stimuli. Except in excessive doses there is no effect upon the cerebral, thalamic or spinal cord areas.

Other less clinically obvious actions of hydroxyzine include a reduction in spontaneous motor activity, an antispasmodic effect, and blockage of the action of histamine, serotonin, and acetylcholine.[4] It also may protect the heart against certain epinephrine-induced arrhythmias.[1]

## Method of Study

A double blind study was conducted. The patients with the remainder of the patients (251) or a placebo along with a slightly reduced amount of the usually used narcotic (meperidine, 50 to 75 mg.), and a belladonna drug (atropine or scopolamine 0.2 to 0.4 mg.). At the time of the study the resident staff was unaware of the particular ataractic drug under study. The patients selected were scheduled for routine general surgical procedures excluding only the moribund and neurosurgery cases. Approximately 900 patients received general anesthesia, with regional anesthesia administered to 100 patients. There were 365 women and 639 men with an age range of 10 to 84 years.

The patients were evaluated upon arrival in the operating room area for degree of sedation, facility of induction, and course of anesthesia and postoperative recovery. Further to ascertain the patients' impression of the day of surgery, they were seen 24 hours postoperatively by one member of the depart-


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*Atarax supplied by J. B. Roerig and Company.

ment. All data were tabulated and categorized before the code was broken.

## Results

Hydroxyzine hydrochloride was given to 753 patients with the remainder of the patients (251) receiving a placebo (Table 1). There was approximately equal distribution between the sexes. A review of the two groups by ages did not demonstrate any reactions which could be related to the age of the patient.

As to the major anesthetic agent or technic, the patients were divided approximately as follows: 10 per cent regional, 10 per cent a combination of nitrous oxide, thiopental sodium and a muscle relaxant, 50 per cent cyclopropane and 30 per cent halothane. A particular agent or technic could not be correlated as producing any particular problem when combined with hydroxyzine.

The preinduction evaluation of the patients demonstrated that sedation was adequate in 603 patients (80 per cent) receiving hydroxyzine. Sedation was considered adequate in 186 patients (74 per cent) of the control group (Table 1).

TABLE 1*

| | Sedation | | Course of Anesthesia |
|---|---|---|---|
| | Total Pts. | Adequate | Unsatisfactory |
| Hydroxyzine | 753 | 603 (80%) | 181 (24%) |
| Control | 251 | 186 (74%) | 46 (18%) |

*Differences are not statistically significant.

Those patients who received their sedation, either hydroxyzine or placebo, more than 90 minutes preoperatively showed no differences in the degree of sedation. This includes the preinduction, anesthetic, and postrecovery periods.

Unusual reactions such as hypotension, hypertension, bradycardia, and excitement during the induction, operative, and postoperative periods occurred in 181 patients (24 per cent) receiving hydroxyzine as compared with 46 patients (18 per cent) in the control group (Table 1). Tachycardia occurred with equal frequence in both groups.

In the recovery period, more hypotension occurred among patients receiving hydroxyzine. More patients in the control group were considered awake on arrival to the recovery room or were awake 60 minutes after anesthesia was discontinued (Table 2).

TABLE 2. *Recovery Period*

| | Awake in 1 Hour | Post-Op Interview Pleasant Experience |
|---|---|---|
| Hydroxyzine | 569 (77%)* | 603 (80%)* |
| Control | 221 (88%) | 178 (71%) |

*Statistically significant.

The recovery experience of the patient indicated a greater number of calm patients among treated than among control patients. There were fewer patients with excitement, nausea, and vomiting postoperatively among treated patients than among controls.

In the evaluation done 24 hours postoperatively, 603 patients (80 per cent) receiving hydroxyzine reported their experiences for the day of surgery as pleasant, whereas 178 patients (71 per cent) in the control group reported their experiences as pleasant (Table 2).

As determined by the chi-square test the differences in percentages reported for the preinduction sedation and unsatisfactory course of anesthesia are not significant; however, the per cent awake in the control group within an hour and the per cent of patients receiving hydroxyzine and reporting a pleasant experience are significant.

## Previous Studies

A review of available literature indicates that a number of studies along this line have been performed.[1,3,4] These studies include a variety of dosage schedules as well as a variety of associated drugs. Some patients received hydroxyzine alone, others, hydroxyzine plus a belladonna drug, and finally, Dilaudid® or meperidine added to the above. All suggested that preoperative tranquillity was excellent and that there was less nausea, vomiting, and postoperative delirium. There was no evidence of toxicity, hypotension or respiratory depression. However, none of the studies was performed with the double blind technic.

## Summary and Conclusions

This study has been undertaken in an effort to determine the effect of hydroxyzine as an adjunct to the usual premedication drugs. We have found no contraindications to the use of this drug. We found that preoperative sedation was adequate in both patient groups, there being no significant statistical difference in the percentages. More important, however, is that the addition of hydroxyzine did not have a marked additive effect when combined with meperidine. Further, the results of the anesthetic recall study which were statistically significant may indicate a prolonged neuroleptic effect without any obvious side effects as would be seen with standard drugs. There was no discernible effect related to the experimental atropine-like effect of hydroxyzine. Of the complications, more seemed to occur during the operation than at any other time; however, a review of charts indicated that none of these complications could be related to the study drug.

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# Cluster Headache

## Case Report of a Variant Type

LOUIS A. SAFER, M. D.

SYMONDS has described as follows a headache syndrome, which he calls *cluster headache:* "The headaches are unilateral and last for long periods of time. They are agonizing with one or more daily. The onset is usually nocturnal. The duration of the paroxysm is from 10 minutes to as long as five hours. Pain is in the supraorbital region and behind the eye."[1]

Harris[2,3] described a similar syndrome calling it *periodic migrainous neuralgia* and advised alcohol injection of the gasserian ganglia. Horton[4] described 84 cases some of which fit into this category. He described the use of intravenous D.H.E. - 45.®

All agree that the basic physiologic derangement is of a vasodilator type. Although similar to the classic migraine in many ways, the descriptive variants in the clinical pattern warrant an individual category.

Here we present the case of a young man whose clinical symptoms were identical with those previously described, but who was ultimately relieved by surgical intervention with the discovery of anomalies of carotid circulation.

### Case Report

Our patient, a 26 year old white man, intelligent and personable, began to have headaches in 1953. These were always left-sided involving the eye, the orbital and temporal regions, and the side of the face and nose. The pain was knifelike and was generally quite severe. Neurological consultation in 1953 revealed no abnormality. Electroencephalographic findings were normal as well. Blood, urine, and the other usual laboratory studies, as well as x-rays of the skull and spine were entirely noncontributory. Upon the suggestion of his internist, he entered intensive and prolonged psychotherapy but without improvement of headache.

Cerebral angiography was done in 1956 and was judged normal. In an attempt to modify pain pattern, in 1956 a left temporal artery ligation was done. The headache was not modified, demonstrating the mere act of surgery did not "cure" by suggestion. Microscopic examination of the excised tissue showed cells suggestive of "glomus lesion." This was indeed one of the factors that led to the ultimate surgical exploration of the neck when all other therapeutic avenues had been exhausted. Incidentally, and not related, he had a left upper lobectomy in 1958 for encapsulated tuberculosis.

In spite of all effort the headaches increased in frequency, severity, and duration so that by 1959 he was having them several times daily. Originally they had been occurring two to three times a week with periods of complete freedom of from 7 to 10 days. They might be as short as 15 to 30 minutes and as long as one to three hours.

In 1959 he was started on intravenous D.H.E. - 45 with dramatic results, although ergotamine by mouth and rectal and sublingual ergot had been ineffective. He was therefore placed on a regime of D.H.E. - 45, 0.25 mg., by intramuscular injection every night for six of every seven days with modest improvement, but he was still subject to severe episodic pain.

In August 1960 because of anxiety about the toxic effects of the drug (he had noted some numbness of toes), our patient was sent to the headache clinic at Montefiore Hospital in New York. There he was studied intensively and was treated with various experimental chemical agents. Again he experienced no benefit over a period of weeks. Finally in desperation, recalling the possible glomus cells of the temporal artery biopsy, the left side of the neck was explored at the Montefiore Hospital.

The carotid bifurcation was found to be normal, but the internal carotid was almost a direct continuation of the common and was increased in size, while the external carotid was much smaller than usual. Since the ergot preparations had given him relief of his headaches (possibly on the basis of decreasing blood flow through the enlarged internal carotid) it was felt that the common carotid should be ligated. This was done in continuity after 10 minutes of occlusion of the vessel failed to produce any neurological signs. Postoperatively, he no longer had headaches, and they could not be provoked by vasodilator drugs or alcohol. He has been without complaints since this operation.

### Comment

We report this to emphasize that while it is useful to catalogue similar symptom complexes into groups, nonetheless various mechanisms in biology can produce very similar results. This is such an instance. Physicians treating this type of headache should be aware of the occasional possibility of "cure" through surgical intervention. We do not feel that this man has been cured but that his headache has been bypassed, and his entire life pattern has been thereby massively improved.

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# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT P. CARSON, M.D., *President*

### PRESENTATION OF CASE

THIS 27 year old white man, who had been a known diabetic since the age of 13, had the first of multiple admissions to this hospital two years previous to his final admission, for recurrent chronic urinary tract infection and poor control of his diabetes with frequent episodes of acidosis and insulin shock. One year previously he had been found to have a neurogenic bladder with high residual urine and bilateral dilated ureter. During this time his blood urea nitrogen ranged between 37 and 60 mg. per 100 ml.

#### Present Illness

The patient had been discharged just one week prior to this final admission, at which time he had been treated for acidosis and his genitourinary tract infection. He was discharged to continue tetracycline therapy. He had been in his usual health, taking 30 or 35 units of NPH insulin daily until the day prior to admission, at which time he had an episode of weakness characterized by inability to support himself. This was transient, lasting approximately 10 minutes; there were no other symptoms. On the day of admission he vomited during his breakfast; the vomitus appeared to be food which he had eaten the evening before. The vomiting continued throughout the day and there was associated dizziness and lightheadedness. He also complained of having had frontal headache of one day's duration.

#### Physical Examination

The patient appeared drowsy but was responsive. His blood pressure was 165/106; his pulse rate was 88 per minute and regular. The skin showed one or two scars over both tibias. There was opacity of the vitreous on the left eye; the right fundus showed a proliferative retinopathy. The chest was clear to percussion and auscultation. The heart sounds were normal and there was a grade 3 rough systolic murmur heard best in the pulmonic area without radiation. Examination of the abdomen showed a suprapubic mass which could be outlined to just below the level of the umbilicus. No other organs or masses or tenderness could be felt. Bowel sounds were normally active. Neurologic examination in addition to the drowsy state and somewhat dull mentation showed absent deep tendon reflexes in the knees and ankles bilaterally. There were no pathological reflexes present.

Submitted May 31, 1962.

*Presented by*

- Grant W. Gwinup, M.D., Columbus, and
- Emmerich von Haam, M.D., Columbus.

Edited by Dr. von Haam.

#### Laboratory Data

His hemoglobin was 7.3 Gm./100 ml. with hematocrit of 25 per cent; the white blood cell count was 8,100 with 68 per cent polymorphonuclear leukocytes and 32 per cent lymphocytes. The serum sodium was 142 per 100 ml., potassium 4.2/100 ml., chloride 104/100 ml., and $CO_2$ combining power 22 mEq./L. Urinalysis showed a specific gravity of 1.015, contained 2 plus sugar, 160 mg. of protein/100 ml., 8-12 white blood cells, 3-4 red blood cells per high power field, and 3 plus bacteria. The blood sugar at the time of admission was 324 mg./100 ml., the blood urea nitrogen 56 mg./100 ml. Serum acetone on admission was negative; cholesterol was 418 mg./100 ml. with 65 per cent esters; amylase was 45 units.

#### Hospital Course

The nausea and vomiting subsided after the first day of hospitalization and he was able to take small amounts of fluid orally. Intake was supplemented during this time with intravenous fluids. Insulin was given on the basis of color change in the urine, and during hospitalization he had three episodes of documented hypoglycemia. All of these, however, were treated readily and he rapidly responded. A urine culture at the time of admission grew a gram-nega-

tive bacillus which was resistant to all antibiotics except for very high concentrations of tetracycline. Tetracycline therapy was continued during hospitalization. In spite of the apparent genitourinary tract infection the patient remained afebrile. Chest x-ray was normal, as were x-rays of the skull. An upper gastrointestinal series obtained several days after admission showed retained secretions in the stomach with altered peristaltic movements; the duodenal bulb was large and dilated and would remain dilated without peristalsis passing through it.

The blood urea nitrogen, which had been 56 mg. per 100 ml. on admission, dropped to 46 mg. on the third hospital day and subsequently began to rise and by the fifteenth hospital day was 119 mg. Over the course of hospitalization fasting blood sugars taken in the morning ranged between 40 and 450 mg. Oral intake of food and fluids remained relatively poor, and he required supplementation with intravenous fluids. During this time his electrolytes remained relatively normal except for a mildly low serum sodium of roughly 133 mEq. On the fourteenth hospital day the patient had developed *Monilia* infection in the mouth and tetracycline was discontinued and Mycostatin® was started. Over the first week of hospitalization the patient was given transfusion with whole blood with a rise in the hemoglobin from the 7.3 Gm. per 100 ml. at the time of admission to 13 Gm. following transfusion.

On the fourteenth hospital day a Foley catheter was placed in the bladder, at which time there was 300 cc. of residual urine. The Foley drainage was continued during the remainder of hospitalization. Twenty-four hour determinations of urine protein on two occasions were less than 1 Gm. total. He continued to show a progressive rise in his blood urea and on the seventeenth hospital day this was 137 mg. On the twentieth hospital day he began having loose diarrheal stools which on smears showed gram-positive organisms resembling *Staphylococcus,* but culture was negative for pathogenic organisms. On the twenty-first hospital day a pure culture of *Staphylococcus* was grown from his urine, which was repeated the following day. Blood cultures were not obtained.

On the twenty-first hospital day he began having difficulty maintaining his blood pressure, which dropped to levels of 60-70 mm. Hg systolic. His pressure was initially supported with Neo-Synephrine® drip. At this time he was started on Chloromycetin® and streptomycin. For the first time he became febrile with a temperature up to 101°. This subsided within twenty-four hours and his temperature remained at approximately 99° for the rest of hospitalization. His blood pressure became progressively more difficult to maintain even with vasopressors, and the diarrhea continued without improvement. He continued to receive intravenous fluids for hydration, but despite this he became progressively less responsive, his blood pressure could no longer be maintained, and he died on the twenty-fifth hospital day.

## CLINICAL DISCUSSION

DR. GWINUP: The case that we have to consider today is that of a young man who was ravaged by the complications of diabetes, and when I use the word "complications" I may be using it incorrectly because there seems to be an accumulating evidence to indicate that the so-called "complications" of diabetes mellitus are not complications but as much a part of the disease as the hyperglycemia, which of course is the easiest for us to measure. My teachers taught me that if young diabetics like this man were carefully managed they did not develop the so-called "complications" of diabetes. But unfortunately in my experience this hasn't been true. I think that anybody who has a chance to come in contact with a good many diabetics has seen patients like this, and it seems to occur in the carefully controlled patient as well as in the carelessly controlled patient.

### Neurogenic Bladder

This was a 27 year old man who we are told right off had chronic urinary tract infection and a dilated bladder. It is hard to know if he would have had chronic urinary tract infection if he had not had a dilated bladder, because we know that diabetics tend to have a high incidence of chronic pyelonephritis, but he had a good reason to have it. It was described as a neurogenic bladder, which sounds like a lower motor lesion affecting the innervation of the bladder, and diabetes is a common cause of such a lesion. From his elevated blood urea nitrogen we know that this was a man with long-standing renal disease and severely compromised renal function.

Not infrequently as a diabetic enters the end-stage of his disease, and I think this is where this man was at his last admission, we find that the insulin requirement tends to go down, and a juvenile diabetic who has been requiring 45-50 units of insulin for years will taper off until he requires no insulin at all. This occurs particularly in diabetics with renal disease, and I think that there are probably two explanations: First of all, as soon as they become uremic at the end-stage of their disease, they do not eat properly, and secondly, I think that there is accumulating evidence that kidney tissue is an important tissue for the metabolism and inactivation of insulin.

Shortly before admission he had an episode which I don't think I can really say much about. It does not sound like an insulin reaction from the way it is described. Could he have had a cerebrovascular accident? This is possible. It doesn't sound to me like a subarachnoid hemorrhage, which is the usual kind of cerebral accident that a young man gets into, but on the other hand the arteries of a young diabetic are frequently more like the arteries of an older, normal individual, and it is conceivable that he might have had some sort of a mild stroke. Could he just

have had an episode of postural hypotension? We know that another common symptom in patients with diabetic neuropathy is postural hypotension because of degeneration of the sympathetic nerves which control the constriction of the arterioles as compensation for assuming the upright posture. We are also told that he had some other symptoms that are not specific by any means. I don't think there is anything to suggest that he had a meningitis or anything of that nature.

On physical examination the blood pressure was elevated and one wonders if it might have been more elevated previously. The presence of scars over both tibias is a common thing to see in diabetics. I think this is usually the result of their neuropathy. They tend to bump into things, to burn and bruise their legs and not feel it. I think that the grade 3 rough systolic murmur over the pulmonic area is probably an insignificant finding and probably related to the anemia which the patient had. I would call it a hemic murmur and do not think this patient had any organic heart disease. I am certain that the suprapubic mass was the bladder. It would have been nice to have been told that it disappeared when the patient voided or was catheterized, which is the best presumptive evidence that it was the bladder. There were no pathologic reflexes present.

## Renal Acidosis

From the laboratory data we can presume that he had essentially a normochromic anemia. We don't have any indication of why he might have this anemia with the probable exception that he had chronic renal disease. He could have had some blood loss from other sources, but since there is really no good indication of anything like this we will explain it by his chronic renal disease. The rest of his blood workup and his electrolytes were normal with the exception of the $CO_2$ combining power, which was slightly reduced. I think this is what you would expect with his elevated BUN, and it really does not lead you to conclude that he had a diabetic acidosis. If he had significant diabetic ketosis, you would expect of course a much more significant depression of the $CO_2$. He undoubtedly had 4 plus acetone in his urine, as almost any individual who has been vomiting for a short time and unable to eat, but particularly a diabetic, will have. So the people who saw him wondered if he might be in diabetic acidosis and did a serum acetone, which was negative. So they knew right away then that the man did not have diabetic acidosis and that there was no need for further concern.

His urine showed a specific gravity of 1.015, contained 2 plus sugar and 160 mg. of protein per 100 ml. The question often comes up: How much do sugar and protein in the urine influence its specific gravity? You have to have a pretty heavy proteinuria and glycosuria to increase the specific gravity of the urine. This man's specific gravity was essentially that of the glomerular filtrate, and I imagine this was because he had a kidney which was unable to concentrate his urine. I imagine that he had a pretty good output of urine although I don't recall seeing in the protocol any measured outputs. He had bacteria in his urine and a positive urine culture, which would confirm the impression of chronic pyelonephritis. If you see bacteria in a properly collected urine specimen you can be certain that these are significant bacteria, and I think that this man did have significant urinary tract bacterial infection.

## Nephrotic Syndrome

His cholesterol was markedly elevated, which is very interesting. A heavy proteinuria and a high cholesterol in a diabetic would make you think of the so-called nephrotic syndrome. He had the lipid abnormalities that accompany or result from the protein leak that develops in the kidney. Diabetics run slightly higher cholesterols than normal individuals, although there is such a tremendous overlap that this seems not significant. Somebody thought he might have pancreatitis, but his serum amylase was normal.

The patient was treated with tetracycline, which was continued all along. He had a series of x-rays which showed that his heart was not enlarged. The gastrointestinal series showed retained secretions in the stomach, which might indicate that his stomach was not working properly either because it was obstructed or because it was inherently incapable of propelling the food through, which is just another manifestation of his diabetic neuropathy. First his blood urea nitrogen dropped, which can be explained by rehydration, but then it rose steadily. On the fourteenth hospital day the patient developed a monilial infection in the mouth, and tetracycline was discontinued and Mycostatin was started. He was also given transfusion with whole blood and his hemoglobin was brought up to a respectable level. On the same day Foley drainage was started and continued throughout his hospitalization.

Twenty-four hour determination of urine protein on two occasions was less than is usually seen with the nephrotic syndrome, but this is what you might expect to find in a man who is in the terminal stage of his disease, which I think he was. On the twenty-first hospital day he began having difficulty maintaining his blood pressure and subsequently he had a rather rapid downhill course terminating in death.

## Triopathy of Diabetes

I think that this man is a beautiful example of the so-called triopathy of diabetics. He had severe retinopathy, he had many manifestations of neuropathy, and he undoubtedly had nephropathy, and I hope that Dr. von Haam will show us some beautiful pictures of diabetic nephropathy. Many years ago LeCount suggested that patients with diabetes may have

two kinds of vascular disease: They may have the atherosclerosis which we all have although it tends to occur earlier and to be more severe, but he postulated that they also have a different kind of vascular diseases, and I think that if there is any lesion that can explain all manifestations of the diabetic triopathy it is the vascular lesion. I don't think the problem is finally settled, but I think that there is a lot of inference that such is the case. The lesions appear in the very small ramifications of the arterial tree and consist of an accumulation of PAS positive material in the walls and lumens of the arterioles. The same lesions have been found in the kidneys, the eyes, and everywhere they have been looked for including the heart.

These vascular lesions appear in very early diabetes and in fact in prodiabetics. The prodiabetic patients are those with a family history of diabetes, or a woman who has had a 12 lb. baby, or patients with a positive glucose tolerance test. These patients were studied by renal biopsies and they had the same kind of lesions which we find in diabetics of long standing, not so severe, of course, because these lesions can be definitely correlated with the duration of the diabetes. I also think that diabetic neuropathy occurs at any stage of the disease. It can be present in patients with asymptomatic diabetes who have only a positive glucose tolerance. We also have known for a long time that an ophthalmologist occasionally makes a diagnosis of diabetes when he sees a patient who comes in to get glasses. So these vascular lesions can occur in early diabetes. I think there is inconclusive evidence to show whether the control of the diabetes has anything to do with the eventual development of the vascular lesion or not. At this time this is still an unsettled question.

### Etiology of Diabetes

Let me finally just speculate a little about the etiology of diabetes, because there are several interesting things that have come out in the last few years that bear upon the question. Since insulin assays have become available, we have been rather surprised to find that diabetics in the early course of their disease, and even later in the course of mild adult diabetes, put out more insulin than normal individuals. In severe juvenile diabetes they do eventually put out much less, or practically no, insulin, but at the start they put out more insulin. The possibility has therefore been raised that diabetes is indeed an immune disease involving auto-antibodies which can neutralize insulin and make it ineffective. Therefore the pancreas of the diabetic has to secrete more insulin and eventually becomes depleted and exhausted. People have gone even further in their speculation and have compared the vascular lesions in diabetics with those of other immune pathologic conditions, like the various types of vasculitis, rheumatic arthritis, etc. They suggest that this material which is deposited in the blood vessels may be the morphologic evidence of an antigen-antibody reaction in which the insulin would represent the antigen. I am sure this is a big simplification, but I just present it because I think it is very interesting and shows our new trend of thinking about the etiology of diabetes.

What then did this man have? I think we are going to find that he had widespread vascular disease. I think he died more of renal failure and sepsis than anything else. In any diabetic who dies of renal failure you have to think of other things than just routine diffuse renal disease, and I think we should think about renal papillary necrosis or something like this. There is no indication of it, but I am just going to mention it in case Dr. von Haam tells me that that is what he had. I think he had evidence of long-standing bacterial infection in his kidney and that probably he had bacterial colitis. I think that he might have a widespread fungus infection throughout his body. I think it is really hard to know exactly why he died. I hate to say that sepsis, uremia and severe vascular disease just led to a depletion of his vital forces, but that is about the best I can come up with.

#### CLINICAL DIAGNOSIS

1. Severe diabetes with:
   (a) Diabetic nephropathy
   (b) Diabetic retinopathy
   (c) Diabetic neuropathy
2. Uremia
3. Sepsis

#### PATHOLOGICAL DIAGNOSIS

1. Diabetes mellitus
   (a) Diabetic glomerulosclerosis
   (b) Diabetic neuropathy
   (c) Diabetic retinopathy
2. Acute pyelonephritis
3. Staphylococcal enterocolitis
4. Uremia
5. Septicemia

#### PATHOLOGICAL DISCUSSION

DR. VON HAAM: This was indeed an excellent discussion of the complications of diabetes. The hospital diagnosis was diabetes, Kimmelstiel-Wilson's disease, uremia and septicemia. It was obvious that this case cannot be considered a clinical puzzle and did not present any difficult diagnostic problems. The case was chosen to bring before you the complications of diabetes and to show that even in our modern age with all the antibiotics and hormones we still can do little for a 27 year old man who has diabetes. This patient spent a whole month in the hospital and instead of getting better he got steadily worse. Let us see what the autopsy showed.

His heart was remarkably normal. It weighed only 320 Gm. and was not yet hypertrophied although hypertension must have been present for some

time. There was no myocardial fibrosis, his coronary arteries were in excellent condition, and the murmur must have been purely functional, as Dr. Gwinup has already assumed.

The lungs showed two old calcific lesions in the right lower lobe and microscopically a very early pneumonia was noted. The liver was enlarged and showed marked fatty metamorphosis. Diabetics often have fatty livers and some fatty livers give rise to diabetes, but there is no definite correlation between the two conditions. The pancreas was small and weighed only 32 Gm. The islands were few in number and most of the islands were composed of small dark cells characteristic of alpha cells. We felt that there was a definite reduction in the number of beta cells per island as well as per total pancreas. In addition the pancreas showed atrophy and fibrosis affecting the acinar apparatus. The stomach showed an acute erosion, while the colon showed severe edema with microscopic necrosis of the mucosa and an acute inflammatory reaction. This type of necrotizing colitis may be produced by various organisms but *Staphylococcus* is perhaps one of the most common causes for this lesion. The kidneys were slightly enlarged, pale and finely granular.

The microscopic picture showed the classical lesions of Kimmelstiel-Wilson's disease present in both the nodular as well as the diffuse form of glomerulosclerosis. In addition the kidneys showed an acute and chronic pyelonephritis. The urinary bladder also showed evidence of an acute infection and the severe muscular hypertrophy of a neurogenic bladder. The patient's postmortem blood urea nitrogen examination was only 99 Gm. and his creatinine was 7.6 mg. Examination of the brain, spinal cord and peripheral nerves failed to reveal any morphological changes which could explain his diabetic neuropathy.

*In summary* then, I would like to state that the patient had juvenile diabetes with definite evidence of severe insulin deficiency and diabetic nephropathy and died from diffuse septicemia. I feel that the septicemia in this case was due to a staphylococcus enterocolitis, which in our experience is one of the rare complications of diabetes. I do not think that his cystitis or pyelonephritis was severe enough to have been the cause of his septicemia.

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GONORRHEA THERAPY.— Several different dosage regimens were used in a series of 507 cases of gonococcal urethritis in the male. The best results were obtained with large doses of aqueous procaine penicillin given over a brief period. The factor of high penicillin blood levels appeared to be more important than duration of treatment, total amount of penicillin given, or previous infection. It was not demonstrated how long these high blood levels must be maintained.

Failure rates were as follows with the various dosage regimens:

39.8% — procaine penicillin in oil and 2% aluminum monostearate (PAM), 0.6 million units daily for 3 days (total, 1.8 million units)
44.0% — PAM, 0.6 daily for 9 days (total, 5.4)
16.8% — aqueous suspension of procaine penicillin (APP), 0.6 daily for 3 days (total, 1.8)
14.1% — APP, 1.2 daily for 1 day (total, 1.2)
24.4% — APP, 1.5 daily for 1 day (total, 1.5)
6.5% — APP, 1.5 daily for 3 days (total, 4.5)

All 53 failures from the groups given APP were then given injections of 0.9 million units of APP twice daily three hours apart on two days (total, 3.6 million units), with the result that 49 were cured. The final result, after retreatment of the failures, was a 1 per cent failure rate in the combined PAM groups, which had received a total dose (in 1 or more courses) of 1.2 to 8.1 million units.

Information from published studies of others indicates that some recently isolated gonococci required 100 to 300 times as much penicillin for inhibition as was previously found to be adequate. Penicillin alone is an excellent drug for treating gonococcal urethritis, even the variety that is "penicillin resistant."— ABSTRACT: Leon David Sabath and James J. Kivlahan: *American Journal of Medical Science,* 242:663-672, (December) 1961.

# Maternal Deaths Involving Hemorrhage (Atony)

## With Comment of Consulting Obstetrician and Gynecologist

By the OSMA COMMITTEE ON MATERNAL HEALTH

STATISTICS in the Ohio Maternal Mortality Study reveal that *hemorrhage* leads as a single primary cause of maternal deaths in our area. The same fact is true throughout our nation if we add deaths from ectopic pregnancy and abortion with hemorrhage to other causes of hemorrhage associated with childbirth and the puerperium in Vital Statistics Reports of the United States. Atony is an insidious etiological factor subclassified in the Ohio Study (see Maternal Mortality Report in *The Journal,* November 1961). Herewith, the Committee presents the cases of three maternal deaths from hemorrhage due to postpartum uterine atony.

### Case No. 283

This patient was a 25 year old, white, Para III, who died suddenly 11 hours postpartum. Her general health had always been good; she had had no operations or serious illnesses. The first two pregnancies resulted in full term deliveries of normal living children. Her postpartum courses had been uncomplicated.

The last menstrual period was September 3. During her pregnancy she was seen by her physician regularly since the third month. She was Rh negative and the serologic test for syphilis was negative. There were no complications until two days before admission, when she had scanty vaginal bleeding. She entered the hospital in active labor on June 22 at 3:35 a.m., 41 weeks gestation, in labor two hours. She progressed "slowly but steadily" in labor. Her blood pressure was 94/60 and the fetal heart tones were 132. Analgesia was Demerol® 100 mg. on two occasions, the last at 11:15 a.m.

She was taken to the delivery room at 12:15 p.m., at which time the record showed that the cervix was completely dilated, the perineum bulging. Under "Nitros and Trilene®" anesthesia an *11 lb. infant* was delivered with low forceps over an episiotomy at 12:38 p.m. The third stage of labor was completed at 12:40 p.m.; there was 600 cc. estimated blood loss at the time of delivery. The episiotomy and a two-inch cervical laceration were repaired. The patient was given Ergotrate® and because of the "moderate uterine atony" 1,000 cc. of 5 per cent glucose in water containing one ampule of Pitocin® was running intravenously when the patient was returned to her room.

She apparently continued to bleed in the postpartum period and on several occasions the nurse's notes record, "fundus boggy, lochia moderate; with massage the fundus is firm." At 2:00 p.m. June 22 a nurse recorded that the patient was found in a "pool of blood" estimated at between 1,000 and 2,000 cc. The uterus was soft and boggy and she was bleeding actively. She was unconscious, with blood pressure 50/0. The intravenous infusion was not running and the pulse rate was 120 to 160 per minute. She was immediately treated with transfusion of "O" negative blood until properly typed blood could be made available and then 5 units were given rapidly. The blood pressure rose to 80/60.

The patient continued to bleed. She was readmitted to surgery, where a curettage with dull curette was done after an intra-uterine examination. There were no retained products of conception. The uterus was intact, but a vaginal wall laceration and additional cervical lacerations were found. These were all repaired along with additional sutures placed in the cervical laceration previously found. The uterus was then packed with gauze. Although the bleeding slowed down, the patient's condition was still considered critical. Her blood pressure was 90/50 and pulse rate 120 per minute. During the evening it was 90/60, pulse 140 and respiration rapid. At 10:00 p.m. she responded to questions and visited with her husband. "At 10:45 p.m. she was restless; vital signs were improving, and some bleeding still present." The fundus felt firm. At 11:45 p.m. she stated that she could not breathe and lapsed into unconsciousness. Suddenly she became pulseless and respiration stopped. Intracardiac Coramine® was administered, but the patient did not respond. Autopsy permission was obtained.

*Pathological Diagnosis:* (Partial—no protocol) Massive postpartum hemorrhage uterine atony; multiple lacerations of cervix and vagina; circulatory failure.

### Comment

The Committee, after a lengthy discussion, voted this a preventable maternal death. Several points of interest were developed: Members felt that with an intrapartum hemorrhage (estimated 600 cc.) a *thorough,* systematic examination of the uterine cavity, the cervix, and the vagina should have been made at once. Following this, *all* visable and palpable lacerations should have been sutured securely. Blood should have been ordered at once to augment the intravenous infusion; it is wise to start this fluid through an 18 gauge needle, and make sure the *flow* is *secured!* Calcium gluconate is often a helpful therapeutic agent in the face of hemorrhage and uterine atony. The patient who experiences intrapartum and/or postpartum hemorrhage must be kept under *close scrutiny* for at least an hour postpartum. Members of the Committee reiterated remarks on the futility of *packing* the uterus in the face of hemorrhage. Prevention

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

of similar catastrophes begins in *anticipating* conditions under which they *may* occur, viz., multiple pregnancy, polyhydramnios, large babies, long and exhausting labors, as well as the occasional "Pit-drip" inductions of labor.

### Case No. 306

This patient was a 34 year old white, Para III, who died eight hours postpartum. In the past history her general health had been good. She had an appendectomy at age 20, and a tonsillectomy and adenoidectomy in childhood. Her two previous pregnancies had resulted in normal gestations, with low forceps deliveries of normal infants at term. The postpartum periods had been uncomplicated and her youngest child was 10 years of age.

She had been under the care of her attending physician since the second month of the present pregnancy. She was Rh positive type A and the serologic test for syphilis was negative. She had had some nausea and vomiting during the fourth and fifth months of gestation and albuminuria on two occasions. Her blood pressure readings ranged between 120/60 and 130/70 and no note is made of edema or other evidence of toxemia. The chart does not reveal treatment she received for these conditions.

At term she was admitted to the hospital on August 20 at 12:30 a.m. in early active labor. Her blood pressure on admission was 126/70. At 4:00 a.m. she was given 100 mg. of Seconal®, and at 6:20 a.m. she was given 60 mg. of Nisentil® and .4 mg. of scopolamine. At 10:10 a.m., 30 mg. of Nisentil and .2 mg. of scopolamine. At 11:00 a.m. x-ray pelvimetry was done, which revealed "narrowed anteroposterior mid-pelvis and outlet diameters." At 1:55 p.m. suddenly she had a convulsion; her blood pressure was 140/60. She was given ether and oxygen, plus 10 per cent glucose in water (apparently for the convulsion). "The fetal heart tone increased to 160 and the cervix was found to be completely dilated with the presenting part at low mid-pelvis." She was then taken to the delivery room and delivered with mid-forceps under gas-oxygen-ether anesthesia administered by a physician. The delivery at 2:00 p.m. was described as "easy mid-forceps," with a first degree laceration. She was given Pituitrin® and Ergotrate®.

Blood pressure at 3:15 p.m. was 146/88. At 4:15 p.m. it was 146/88. At 5:00 p.m. it was found that the patient's fundus was *relaxed*. Hemorrhage of two pints was listed! She was given Ergotrate and Adrenosem®. Her color was poor in spite of continuous oxygen. At 5:40 p.m. small clots were expressed and her red blood cell count was 3,860,000 with 12.2 Gm. hemoglobin. She was given 1 unit of blood, 1,000 cc. of 10 per cent glucose in distilled water, with 500 mg. of vitamin C. At 8:10 p.m. her blood pressure was 98/80. Ergotrate and Pituitrin were repeated three times in seven hours, without result. The uterus was massaged. Her condition gradually deteriorated, and she died at 10:15 p.m. There was no autopsy.

*Cause of Death* (certificate): Myocardial failure; hemorrhage, childbirth; (Not listed: uterine atony and convulsions intrapatrum).

#### Comment

The actual course of events in this case was difficult to assemble by the Committee, due to omission of many details in the summary, and lack of an autopsy. Obviously, the *"cause* of death" as listed left many features to be explained. In a lengthy discussion of facts, as presented, Committee members wondered (1) Why x-ray pelvimetry in a "multip" progressing well in labor? (2) Was ether really administered *for* the convulsion? (3) What was the birth weight of the baby? Was it alive? (4) Was this really an "easy *mid-forceps"* delivery? (5) Why was not a thorough exploration of the birth canal (including uterus) done, especially when hemorrhage occurred? (6) When did the membranes rupture? (Members felt that amniotic fluid [pulmonary] embolus, or ruptured uterus following trauma, might well have figured in factors causing the death. Certainly uterine *atony* [mentioned in the text] does not explain many of the bizarre features in the case.)

After studying the available information, the Committee voted this a preventable death.

### Case No. 402

This patient was a 21 year old white, Para II, who died four hours postpartum. Her previous pregnancy was uncomplicated and delivery had been accomplished at term by low forceps and episiotomy with some difficulty not explained by the record. Her past general health had been excellent and she had had no operations or serious illnesses.

The last menstrual period began July 8. This pregnancy had been under the careful supervision of her physician since the second month of gestation and her prenatal care was considered adequate. Her only complication had been slight edema in the last two weeks of pregnancy. This was successfully treated with Diamox®. She was Rh positive type A and her serologic test for syphilis was negative. There were no abnormalities noted on physical examination.

At term, she was admitted to the hospital in active labor on April 9 at 9:50 a.m. She had good labor with adequate sedation according to the chart. The vertex presented and the weight of the baby was thought to be less than the previous infant. She progressed in labor to complete dilatation, but the vertex arrested in a left occiput transverse position with descent to the perineum. She was given a spinal anesthetic, supplemented with gas, and "Kielland forceps were applied. Rotation to anteroposterior position was accomplished with some difficulty." Delivery was completed after a "tough" pull. The baby's condition was satisfactory. It weighed 7½ lbs.

The placenta was expelled spontaneously and was followed by brisk bleeding, estimated at 2,000-3,000 cc. Shock ensued immediately! Vaginal examination revealed lacerations in the right vault and fornix. The uterus was intact and empty on exploration. The patient was given oxytoxics and transfusions while unsuccessful attempts were made at controlling the bleeding by suturing, Oxycel® and vaginal packing. Internal bleeding seemed evident and an abdominal exploration was done revealing bleeding into the right broad ligament and venous plexus. Hysterectomy was done, but the patient never reacted from the shock and died four hours after delivery. Autopsy was permitted.

*Pathological Diagnosis:* (No protocol); postpartum hemorrhage, due to lacerations of vaginal vault and fornix; hemorrhage into broad ligament and venous plexus; irreversible shock.

#### Comment

The Committee voted this a preventable maternal death. Members felt that indications for the use of Kielland forceps were certainly present, but that there was some error in application of the instrument rendering definite trauma to soft tissues of the pelvis. These forceps were originally designed *only* for rotation of the fetal head; no mention was made of application of a second forceps designed for traction. In the face of some disproportion the choice of a more suitable forceps for use after the head was occiput-anterior would have seemed appropriate. Although the measures employed after the catastrophe was discovered were applicable, it appears they were initiated too late.

#### Comment of Consultant

The following comment of a consultant who is a specialist in obstetrics and gynecology, was furnished at the request of the Committee:

"The most dangerous five minutes in pregnancy

is that following the expulsion of the placenta. The sudden, massive hemorrhage that can occur at this crucial period from an atonic uterus is horrifying both in appearance and sequelae.

"I feel that the committee has evaluated these three cases very well, and I agree with their decisions, made as best they could be on the incomplete information furnished them and in the absence of autopsy in one instance. Therefore, I would rather confine my remarks to postpartum uterine atony in general.

"The prevention of this condition starts with the first prenatal visit. A healthy mother, free of toxemia, free of infection, with properly appraised pelvis, and in good physiologic balance is the best safeguard against uterine atony. The next is safe, sane childbirth with conservation of blood and examination of the birth canal. Constant vigilance in delivery of the placenta and repair, not only of the perineum, but also of the vaginal vault and cervix alike will forestall dangerous blood loss. Manual exploration of the evacuated uterus after the third stage should be *routine*. The physician should never "break scrub" until the uterus has contracted to his satisfaction. Close observation by trained personnel for one hour post partum is essential to good obstetric care today. Even with this precaution, palpation of the fundus by the delivering doctor, after he has changed his clothes and is about to leave the hospital, may be a lifesaving measure.

"Remember that estimated blood loss is almost always on the optimistic side. This is proven by several current research projects on the subject. We can usually add 200 to 300 cc. to our 'guestimate.' So the normal parturient loses 500 cc. and the estimated 500-600 cc. hemorrhage is probably closer to 1000 cc. It is better to order the blood and not use it than to order blood too late!

"The initial 'gush' from an atonic uterus can be checked by bimanual compression of the organ, one hand in the vagina, the other compressing the abdomen. This compression can be maintained until an oxytocic drip is started and the uterus shows signs of contractility. Intrauterine packing, if used at all, should be only a temporary measure until oxytocics and blood are running or until preparations are made for hysterectomy. Longer periods may conceal hemorrhage or prevent sufficient contraction of the hollow viscus to seal off the venous spaces.

"Although most uterine atonies follow some unusual trauma (mid-forceps, cervical lacerations, difficult breeches, etc.), they may also occur from causes completely beyond the physician's control. Overdistention of the uterus from large babies, multiple pregnancy, polyhydramnios as well as abnormal presentations predispose to this condition. In all cases such as these a 'strong index of suspicion' should make Coast Guards of us all . . . . . 'semper paratus.' "

## Franklin County Pelvic Cancer Delay Committee Report

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee at its April 18, 1962 meeting.

### Case Report

Case No. 100: A 58 year old white woman, gravida 0, Para 0, was seen in her family physician's office on March 3, because of two episodes of vaginal bleeding. Each episode was scanty and of one day duration. Significant points in her past history included dysfunctional uterine bleeding around menopause six years ago at which time a dilatation and curettage was reported by the pathologist to show endometrial hyperplasia. During her current visit, pelvic examination revealed a uterus upper normal in size, small atrophic ovaries, and a cervix with healed transverse lacerations. A Papanicolaou smear was reported negative for malignant cells. A diagnosis of diabetes was established at this time.

During the next 12 months, she was seen at regular intervals in an effort to control her diabetes. On September 14 she had experienced a four day episode of vaginal bleeding but neglected to reveal this to her physician. One week prior to her hospital admission, she reported a 10 day episode of continual vaginal bleeding with passage of blood clots. Examination revealed an obese woman whose blood pressure was 138/90, and she appeared anemic. Pelvic findings included a uterus two and a half times normal size with a relatively clean cervix but with active bleeding through the external os. She was hospitalized on March 10 and given blood transfusion. Her diabetes stabilized. On March 14, a dilatation and curettage revealed adenoacanthoma. She was then referred to the Gynecology Tumor Clinic at Ohio State University Hospital for definitive therapy.

On March 27 she was hospitalized at University Hospital where a fractional and endometrial curettage and cold knife conization of the cervix confirmed the diagnosis. Central irradiation consisted of $CO_{60}$ Beads plus Manchester Ovoids with a short endocervical tandem to irradiate the upper vaginal cuff. Six weeks post-irradiation, a total hysterectomy, bilateral salpingo-oophorectomy and resection of the upper vaginal cuff was performed.

### Comments

If there is a model type patient who is prone to develop endometrial carcinoma, the patient under discussion fills the necessary criteria, ie, a delayed menopause associated with dysfunctional uterine bleeding (hyperplasia), obese, metabolically disturbed, with several episodes of postmenopausal bleeding. A negative Papanicolaou vaginal smear does rule out endometrial carcinoma since its accuracy lies between 50 and 60 per cent. Constructive criticism is directed towards both physician and patient delay in not aggressively pursuing menopausal and postmenopausal vaginal bleeding. Physician delay is further compounded by not recognizing the importance of endometrial hyperplasia reported during the first uterine curettage. Adequate therapy for endometrial carcinoma has been outlined in this protocol.

### Delay

*Physician Delay:* Six Years.

*Patient Delay:* Six Months.

Special Article

# Laryngectomees in Ohio

WARREN H. GARDNER, Ph. D.*

AS EARLY as 1936, Julius McCall, M. D., of Cleveland, was sending his prospective laryngectomees to interview a patient who had previously received a laryngectomy. Likewise, about the fifth or sixth day after surgery he had two or three laryngectomees visit the patient in the hospital. The purpose of these visits was to furnish the patient with assurance that he would survive, just as the other patients had; that he would be able to talk again; and that he would be going back to his job.

Laryngectomized patients of surgeons in the Cleveland area began to increase in sufficient numbers to need a teacher for their speech program. She was Mrs. Florence Fross, a laryngectomee who had been taught speech by Dr. McCall. Classes were held in 1945 at the Cleveland Hearing and Speech Center. Under the sponsorship of Amy Bishop, senior speech therapist at the Center, Julius McCall, M. D., and Normand Hoerr, M. D., professor of anatomy at Western Reserve University School of Medicine, laryngectomees organized the Cleveland Lost Chord Club in 1947 to furnish group instruction and recreational rehabilitation to the newly laryngectomized patients. This was one of the first clubs for laryngectomees to be formed in the United States. It was also designed to emphasize the fact that patients were now surviving cancer of the larynx. A similar club was organized in the same year by pupils of J. S. Greene, M. D., laryngologist and head of the National Hospital for Speech Disorders in New York City. At the same time, the Cured Cancer Club was started in Boston.

## Clubs for Laryngectomees

Meanwhile, speech pathologists at Ohio State University began a study of the speech of laryngectomees, and they began to interest these patients in starting a club in Columbus. This was accomplished in 1952. Laryngectomees from cities in the United States and Canada, hearing about these clubs, visited the Cleveland Lost Chord Club. They returned to organize clubs in their own cities. When I heard about formation of clubs in Louisville, Detroit, St. Louis, Philadelphia, Memphis, Atlanta, Toronto, and Florida, I decided that an international organization would be valuable in promoting national and international services for laryngectomees. Thus, in 1952, the International Association of Laryngectomees was organized in Cleveland at the First Institute on Voice Pathology of the Cleveland Hearing and Speech Center.** Financial sponsors of this first meeting were the Cuyahoga Chapter of the American Cancer Society and the National Institutes of Health. Starting with 11 original clubs, the Association now has 83 with a membership of 8000 in the United States, Canada, France, England, Japan, Australia and New Zealand, and 10 other affiliated clubs. The American Cancer Society has financially supported the Association since 1954. The Association has held 10 international sessions, entertaining laryngectomees, speech pathologists, public health officials, and surgeons from all parts of the world.

## Pre- and Post-Operative Orientation

Meanwhile the Cleveland Lost Chord Club was expanding its activity program. In order to establish uniform procedures and control of the orientation program, a set of three pamphlets was prepared by the laryngologists of the Medical Advisory Committee of the Cleveland Hearing and Speech Center and by officers of the Cleveland Lost Chord Club. Printing of these pamphlets was financed by the Cuyahoga Chapter of the American Cancer Society, by the Cleveland Hearing and Speech Center, and by the Cleveland Lost Chord Club.

## The Surgeon's Role

*Pamphlet No. 1 was addressed to the surgeon.* It presented the basic steps of the orientation program:

a. Preoperative orientation and speech therapy;
b. Postoperative visitation (hospital visit by a visitant);
c. Referral to a speech therapist;
d. Referral to a Lost Chord Club.

This pamphlet was distributed to all surgeons in Cleveland who do laryngectomies; and it was planned

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**Proceedings First Institute on Voice Pathology, Cleveland Hearing and Speech Center, 11206 Euclid Avenue, Cleveland 6, Ohio.

to deliver one to any surgeon who begins to perform this surgery.

### The Visitant's Role

*Pamphlet No. 2 was addressed to the visitants.* It explained that visitants to laryngectomees in the hospitals had to be carefully selected, by the following criteria:

a. Intelligible, fluent, and well-phrased esophageal speech;

b. Successful adjustment to the problem of communication;

c. Successful emotional adjustment;

d. A pleasant personality free from secondary, undesirable speech habits.

Instructions were given in the pamphlet about what the visitant should say to the new patient. In the *preoperative visit* he may explain the method he uses to speak without a larynx. He should urge the patient to swallow air and return it to the mouth for practice in making speech sounds, and do this as often as he can before surgery. During *the postoperative visit,* the visitant introduces himself as a member of the Lost Chord Club, sent to see him by the patient's surgeon. He invites the patient to become a member of the Lost Chord Club, or to join one nearest to his home town. He explains how he went through the same situation as the patient, and that he now is talking, and is back on the job. The visitant is urged to convey the impression that he has successfuly handled his postoperative adjustments. A word of warning in the pamphlet is that the visitant must not call on any other patient in the hospital without permission from the attending surgeon.

*Pamphlet No. 3 is for the patient* and is given to him by the visitant. A motto on the face of the pamphlet reads: "Thank God He has given us two voices in a single lifetime." Its contents cover answers to many questions, such as: Why did this happen to me? Will I live? Will I talk again? Will I be able to work? Why the hole in my neck? Special directions are given for safe hygiene of the stoma. The patient is invited to join the nearest Lost Chord Club, and is urged to start learning speech as quickly as the surgeon permits it. On the back page is a list of clubs in Ohio, western Pennsylvania, eastern Indiana, Detroit, and New York.

When the surgeon wishes to have a prospective surgical patient interview a laryngectomee he calls the appointment clerk at the Cleveland Hearing and Speech Center, who in turn arranges the interview, which includes showing the Center's film, *New Voices.*† About six days after surgery, or when he considers the time appropriate, the surgeon makes a second request for three visitants to call on the patient in the hospital. The appointment clerk telephones three visitants taken from a list approved by the surgeons and the officers of the Cleveland Lost Chord Club.

The following Clubs are now active in Ohio, with the date of organization and membership:

| City | Date of Organization | Mailing List |
|---|---|---|
| Cleveland | 1947 | 259 |
| Columbus | 1952 | 160 |
| Kent | 1952 | 15 |
| Bowling Green | 1954 | 85 |
| Youngstown | 1956 | 60 |
| Akron | 1957 | 65 |
| Steubenville | 1960 | 25 |
| Dayton | 1960 | 40 |
| Athens | 1961 | 15 |
| Warren | 1961 | 15 |

### Speech Lessons for Laryngectomees

The local chapters of the American Cancer Society furnish free speech lessons to the members of these clubs, which comprise 14 per cent of all the clubs of the International Association of Laryngectomees. In 1958 the Laryngectomee League of Ohio was formed by officers of the Ohio clubs at a meeting held at the Marion County Fairgrounds. Walter Park of Akron was the first president. It is supported financially by the Ohio Division of the American Cancer Society. The League is promoting organization of new clubs, and is urging surgeons of the state to adopt the preoperative and postoperative programs for laryngectomees, some of whom are still being operated upon without orientation or information about speech therapy.

### Hygiene and Clothing

Efforts are directed toward encouraging all clubs to participate in the social and speech rehabilitation of laryngectomees. Wives of the members are urged to encourage their husbands to keep on talking. They knit hundreds of bibs which the patients need to cover their stomas. Laryngectomees are urged to cover their stomas at all times when in public, in order to serve as good examples to newly operated patients; and to prevent annoying experiences that may come from a sudden cough, or breathing out forcefully while talking to a stranger. The clubs also distribute manuals‡ for learning esophageal speech; give speech instruction, both group and individual at each session; and offer recreational activities.

### Lifesaving and Safety

In addition to social and speech services, the Cleveland Lost Chord Club has been active in promoting lifesaving and safety measures for laryngectomees. A recent incident in a hospital proves the impor-

†Two versions of this film are obtainable: a black and white training film, and an added color section for nurses and physicians. Julius McCall, M. D., was the medical consultant for the film's production.

‡*Your New Voice,* and *Esophageal Speech,* are speech manuals which may be obtained through your local Cancer Society.

tance of this program. A laryngectomee was injured in a motor accident. When he was brought to the emergency room, the receiving staff decided to send him to Cleveland because they didn't know how to work with a person who had a "hole in his neck." Another laryngectomee was admitted to a hospital for treatment of pneumonia. The attending nurse tried to put the feeding tube down his stoma into the trachea. The patient jerked it out twice before the nurse understood that this was his breathing opening. A third laryngectomee fell from a motor boat but was rescued quickly. However, he died, because no one knew how to get the water out of his lungs through the stoma, or how to use chest massage.

Heading a team of laryngectomees, Dr. J. F. Pekarek of the Cleveland Lost Chord Club with the club's officers, and Captain Ed Prebe of the Newburgh Heights Fire Department have given 15 demonstrations of safety measures for resuscitating laryngectomees who have been in water; who have been exposed to fire and smoke; or who have become unconscious for unknown reasons. They have spoken to state firemen's and fire chiefs' associations as well as to local fire department districts. The important message they are putting across is that placing the oxygen mask over the face of the laryngectomee is useless. The patient breathes through the hole in his neck. Hence, the mask must be put over the stoma, and a small one such as a baby mask may be best used for this purpose. The head of the patient must be kept lowered backward to keep the stoma from closing. Colored slides and tape recordings produce a very effective method of explaining the laryngectomees' emergency problems to safety officials.*

### Laryngectomees in Industry

A survey has been made of laryngectomees employed in dusty places. It was found that many of them work in grinding departments, steel mills, potteries, grain separation units, farms, coal mines, and paint factories. Dust particles and gaseous mixtures pass directly into the lungs because the air they breathe is no longer screened by the nose. Masks are now being designed to protect the laryngectomee and thus give him support for returning to his job.

### Summary

The early 1940's marked an era of survival for patients with cancer of the larynx. This necessitated teaching them speech. Groups of these patients formed clubs, nine of which are in Ohio. There are 72 altogether in the United States, and other countries, all of which are members of the International Association of Laryngectomees, founded in 1952 in Cleveland. Club members furnish opportunities for newly laryngectomized patients to receive recreational and social rehabilitation as well as to learn speech. The members also serve as visitants for the surgeons, who request visits to the hospitals for preoperative and postoperative orientation. These visits prevent depression by encouraging the patient to get well and to learn to talk all over. In order to establish suitable, uniform programs of orientation, the Cleveland laryngectomees and surgeons have prepared three pamphlets: for the surgeon, for the visitant, and for the patient.

*For more information write Dr. J. F. Pekarek, 5644 Broadway Avenue, Cleveland, Ohio.

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TO SPEAK FITLY *one* of the greatest assets a professional man can have, assuming, of course, that his professional learning is adequate, is the ability to communicate both by word of mouth and by the written word. The art of communication is fast becoming a lost art in the midst of a plethora of communication media. I recommend that our profession, particularly, exert great care not only in what we say but in how we say it. Use of the words "appraise" for "apprise," "imply" for "infer," might make a patient worry lest the doctor's professional knowledge be on a par with his knowledge of the language. We should certainly encourage our prospective medical students to get as firm a foundation as possible in the humanities during their undergraduate days, with emphasis on how to write and how to speak — Fitly. ("In a fit manner; also, at a fit time.") — (Editorial — reprinted from *Virginia Medical Monthly*, 88:382, 1961.)




# NEWS AND Organization Section

## Kennedy Medical Plan Killed

### U.S. Senate Tables Proposal, 52-48; Senators Young and Lausche Vote for Measure; DiSalle Sorry About Defeat

THE plan to provide compulsory health insurance for Social Security beneficiaries, actively promoted by the Kennedy administration, was defeated on July 17 in the U. S. Senate by a vote of 52 to 48 — a stunning defeat for the Kennedy and labor forces.

This means that the plan is dead so far as the 87th Congress is concerned but it will be a major issue in the Congressional and gubernatorial elections in November.

The vote came on a motion to table a proposed amendment to a House-passed welfare measure. The amendment contained most of the provisions of H. R. 4222, the original King-Anderson Bill, still sleeping in the House Ways and Means Committee.

Ohio's Senators Young and Lausche voted with 43 Democrats and 5 Republicans not to table the amendment — in effect a vote in favor of the Kennedy plan to create a program of health care under Social Security. Thirty-one Republicans and 21 Democrats voted to kill the amendment (against the medicare measure).

President Kennedy in a press conference has asserted the issue will be fought out in the November elections.

Mayor Anthony Celebrezze of Cleveland, named by Kennedy as Secretary of Health, Education and Welfare on July 14, in Washington the day the Senate voted, refused to comment on the subject, indicating he would express his views on medicare and other controversial issues involving his department after he is sworn into office.

Governor DiSalle is sorry that the Anderson-Javits proposal was defeated. In a press conference on July 18, DiSalle commented as follows:

"I am sorry to see it defeated. Those responsible for its defeat will feel the results of their action in the coming months. I am happy that both Ohio senators voted for it, which shows it was not a radical measure. We in state government know what an ever-increasing burden the care of the aged is on the taxpayer."

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## Farm Bureau Groups Oppose Expanded Social Security

"We do not want more Social Security."

That statement reflects the opinion of an overwhelming majority of members of the Ohio Farm Bureau Federation, according to reports of 814 local farm bureau advisory councils.

Reporting on council discussions of the topic "Knowing Your Social Security Program," most of the groups rejected any expansion of the program in general and the King-Anderson Bill in particular, calling it an opening wedge for socialism.

A few groups, however, favored an expanded program, the King-Anderson Bill, and expressed disapproval of the American Medical Association, charges by hospitals and physicians, and drug costs.

# Asks Help on Drug Cost Problem . . .

## Letter Sent to Ohio Physicians Caring for Aid for Aged Recipients by Division's Medical Advisory Committee

A LETTER under date of June 29 was mailed to all physicians who provide services for recipients of Aid for the Aged by William F. Bradley, M. D., chairman, Medical Advisory Committee to the Ohio Division of Aid for the Aged, asking them to cooperate with the division in its attempt to deal with the problem of cost of drugs.

Text of the letter sent to physicians was as follows:

"Dear Doctor:

"The Medical Advisory Committee is attempting to work very closely with the Division of Aid for the Aged and to represent the medical profession at the Division level. The committee has attempted to help solve medical problems which are common to medicine and the Division of Aid for the Aged. One of these problems deals with the cost of drugs to recipients of Aid for the Aged. It has been well established by studies in large hospitals, veterans administration hospitals and similar organizations that the cost of drugs can be appreciably reduced whenever prescriptions are written by considering generic or equivalent terms.

"The Medical Advisory Committee to the Division of Aid for the Aged recently met in Columbus and adopted by a unanimous vote a recommendation to which it would like members of the medical profession, who attend Aid for the Aged patients, to give careful and serious consideration. It was recommended by the committee that whenever a prescription is written, the physician should use either the generic or proprietary name, whichever is his usual practice, and add the words 'or USP or NNF Counterpart.'

"The committee, as well as the Division of Aid for the Aged, wishes the physicians to continue to prescribe for recipients of Aid for the Aged as they would for their private patients, thereby continuing to offer all citizens the best medical care in the world. Since we are dealing with tax monies, it behooves each of us as citizens as well as physicians, to conserve these monies so that they may be used to the greatest possible advantage. Therefore, again, we earnestly solicit your help to prescribe for your patients in the above-mentioned manner.

"If there are any questions or problems which you have concerning this particular item or any problem in the area of Aid for the Aged, please feel free to write to me as Chairman of the Medical Advisory Committee at 497 East Town Street, Columbus 15, Ohio. The committee will make every effort to answer your letter as promptly as possible.

"Thanking you in advance for your consideration and assistance, I remain,"

Very truly yours,

WILLIAM F. BRADLEY, M. D.,
*Chairman, Medical Advisory Committee.*

In addition to Dr. Bradley, members of the Medical Advisory Committee are: John G. Anderson, M. D., Lynchburg; David Creamer, M. D., Bellaire; A. R. Fuller, D. O., Fremont, Earl R. Haynes, M. D. Zanesville; T. A. Makley, M. D., Columbus; Roger A. Peatee, M. D., Bowling Green; P. J. Robechek, M. D., Cleveland; C. W. Stertzbach, M. D., Youngstown; Robert E. Swank, M. D., Chillicothe; and Albert D. Weyman, M. D., Reading.

### Faster Depreciation of Equipment And Services Offered

The Treasury has announced its new tax guidelines which encourage full depreciation of equipment, property and services more rapidly than previously.

Concerning services, which includes personal services such as offered by photo studios and mortuaries, and professional services such as offered by physicians and dentists, full depreciation is now permitted over a 10 year period.

Office equipment, which includes desks, files, safes, typewriters, duplicating machines, and other furniture and nonstructural fixtures, now has a 10 year depreciable life. This was formerly 15 years.

The Treasury Department declares that its depreciation structure for buildings, including office buildings, remains unchanged. The life of an office building is now depreciated over a 45 year period.

### New First Aid Manual

An up-to-date list of dos and don'ts for handling the more common variety of emergencies has been issued by the American Medical Association in a 48-page pocket-size first aid manual. Subject matter ranges from cuts to childbirth and from scorpion stings to mental disturbances.

# AMA Chicago Meeting . . .

## Annis Named President-Elect; Dr. Hudson Re-Elected To Board of Trustees; Summary of Other Business Transacted

DR. EDWARD R. ANNIS of Miami, Florida, chairman of the AMA National Speakers Bureau and AMA's No. 1 spokesman in the campaign against the King-Anderson Bill, was chosen president-elect of the American Medical Association at its 111th Annual Meeting, June 24-28, Chicago.

Dr. Annis will become president at the June, 1963, annual meeting in Atlantic City, succeeding Dr. George M. Fister of Ogden, Utah, who assumed office at the inaugural ceremony in Chicago.

### Dr. Hudson Re-Elected

Dr. Charles L. Hudson, Cleveland, was re-elected to a five-year term on the Board of Trustees. Dr. Hudson, a former president of the OSMA and former AMA delegate from Ohio, was elected to the Board last June for an unexpired term of one year.

The following Ohio physicians represented the OSMA in the House of Delegates: Dr. John H. Budd, Dr. Philip B. Hardymon, Dr. J. Robert Hudson, Dr. Carl A. Lincke, Dr. Richard L. Meiling, Dr. Paul F. Orr, Dr. George W. Petznick, Dr. George A. Woodhouse, and Dr. Edmond K. Yantes. Dr. Yantes served on the Reference Committee on Insurance and Medical Service and Dr. Budd on the Reference Committee on Miscellaneous Business. Dr. Lincke was on the staff of the sergeant at arms.

Alternate delegates from Ohio in attendance were: Dr. Harry K. Hines, Dr. T. L. Light, Dr. Robert S. Martin, Dr. Frederick P. Osgood, Dr. H. T. Pease, Dr. P. John Robechek, and Dr. Robert E. Tschantz. Also, in attendance was Dr. George J. Hamwi, president of the Ohio State Medical Association; the following from the Columbus Office staff: Messrs. Nelson, Saville, Page, Edgar and Traphagan; the following local executive secretaries: Robert F. Freeman, Dayton; Robert A. Long, Cleveland; William Webb, Columbus; Edward F. Willenborg, Cincinnati; S. H. Mountcastle, Akron; and Dr. Donald M. Glover, alternate delegate from the Section on General Surgery; Dr. Walter J. Zeiter, delegate from the Section on Physical Medicine; and Dr. Charles L. Leedham, alternate delegate from the Section on Military Medicine.

### OSMA Auxiliary Honored

The Woman's Auxiliary to the Ohio State Medical Association was honored at the annual session of the AMA Auxiliary. It was presented with an AMA-ERF award of merit for having raised the largest amount of money of any state auxiliary. The Tuscarawas County Medical Society Auxiliary was cited for outstanding efforts. Mrs. William H. Evans, Youngstown, former president of the Ohio Auxiliary, was installed as constitutional secretary. The new president of the national auxiliary is Mrs. William G. Thuss, Birmingham, Ala., and the new president-elect is Mrs. C. Rodney Stoltz, Watertown, S. D.

### Additional Officers

Other officers named by the AMA were as follows: Dr. J. P. Culpepper, Jr., Hattiesburg, Miss., vice-president; Dr. Norman A. Welch, Boston, re-elected speaker of the House, and Dr. Milford O. Rouse, Dallas, Tex., re-elected vice-speaker. Dr. Wesley W. Hall, Reno, Nev., re-elected to a five-year term on the Board of Trustees.

Dr. Elmer G. Shelley, North East, Pa., was renamed to the Judicial Council. Re-elected to the Council on Medical Education and Hospitals were Dr. Warde B. Allan, Baltimore, and Dr. W. Clarke Wescoe, Lawrence, Kansas. Dr. George W. Slagle, Battle Creek, Mich., was elected to the Council on Medical Service, succeeding Dr. Robert L. Novy, Detroit, who was ineligible for re-election.

For the Council on Constitution and Bylaws, Dr. Walter E. Bornemeier, Chicago, was re-elected, and Dr. James Monroe Kolb, Sr., Clarksville, Ark., was named to fill the unexpired term of the late Dr. Walter E. Vest, Huntington, W. Va.

### Future AMA Sessions

Future AMA meetings were scheduled as follows: Clinical session, 1962, Los Angeles; annual session, 1963, Atlantic City; clinical, 1963, Portland, Oregon; annual session, 1964, San Francisco; clinical, Miami Beach; annual session, 1965, New York; clinical, Philadelphia; annual session, 1966, Chicago; clinical, Las Vegas; annual session, 1967, Atlantic City; annual session, 1968, San Francisco.

The AMA 1962 Distinguished Service Award was voted to Dr. Russell L. Cecil, 81, of New York City, senior editor of the *Textbook of Medicine* and one of the nation's leading researchers in the field of arthritis.

Final registration figures at the meeting reached a total of 42,643, including 14,092 physicians.

### Many Issues Acted On

Health care for the aged, medical discipline, composition of the AMA Board of Trustees and the Council on Medical Education and Hospitals, the

American Board of Abdominal Surgery, relations with the American College of Surgeons and voluntary health insurance were among the major subjects acted upon by the House of Delegates.

### Health Care for the Aged

The House received 17 resolutions expressing full support of the Kerr-Mills program and firm opposition to the King-Anderson type of legislation. In reaffirming the position of active opposition to the King-Anderson Bill, the House cited the following reasons: the lack of need for such a plan; that it would provide inadequate care for all aged rather than complete care for those who need help; the fact that inherent in the use of the Social Security mechanism are governmental controls of medical practice which would increase with the expansion of the program; deterioration of the quality of medical care not only for the aged but for the population as a whole.

In reaffirming strong support for the Kerr-Mills Act, the House declared that "the Kerr-Mills method should be given a fair and reasonable chance to meet the need and thus remove the demand for further Federal legislation."

It urged that in states where existing programs indicate a need for a Kerr-Mills implementing law, each state association should actively sponsor and promote with other responsible citizens the enactment of such a law. It also urged the state associations to "work actively with other responsible citizens in reviewing the functions of the law, evaluating its effectiveness and aggressively supporting improvements in programs to aid those aged who need help so as to achieve the provision of quality medical care and service."

### No Action on Non-Participation

The House took no action on one resolution which called for non-participation in the implementation of the King-Anderson Bill, but it urged individual physicians to give particular consideration to the following sections of the Principles of Medical Ethics:

"Section 1. — The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"Section 5. — A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6. — A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioriation of the quality of medical care."

### AMA Delegates Hear Cleveland Academy Praised by Writer

For what may have been the first time in the history of the AMA House of Delegates, a lay science writer was extended the courtesy of the floor to heap praises on the Cleveland Academy of Medicine for its recently completed polio immunization campaign that saw 94 per cent of Cuyahoga County residents receiving Sabin vaccine, representing more than 1.5 million persons.

*Cleveland Press and News* Science Writer Don Dunham, who was extended the courtesy, told the House that it was the greatest demonstration in history of mass immunization programming. Dunham also cited the program as an outstanding example of the community leadership and organization that the medical profession can produce. He said the program reflects great credit on the physicians of Cuyahoga County.

### No Compromise Avowed

Commenting on the Association's fight against the King-Anderson Bill, Dr. Leonard W. Larson, retiring president, told the opening session of the House that the steadfast refusal of the AMA to compromise on basic principles "has been a source of strength for us and our friends." Dr. Larson expressed confidence in ultimate victory, but he added that victory will impose a solemn obligation of responsible leadership for all physicians. Also commenting on the question of compromise, Dr. Fister in his inaugural address said "we will not compromise with those who regard medical care problems as simply playthings in the game of politics — gimmicks to attract the votes of the gullible."

### Medical Discipline

To implement one of the major recommendations made by the Medical Disciplinary Committee at the June, 1961, meeting in New York, the House approved a change in the Bylaws under which a proposed Section 1 (B) of Chapter IV will now read:

"In addition to such disciplinary action as may be taken under the constitution and bylaws of the component society and constituent association to which the Member belongs, or when a state medical association to which a Member belongs requests the AMA to take disciplinary action, or when at the request of the American Medical Association the state association to which the member belongs consents to disciplinary proceedings by AMA, the Judicial Council, after due notice and hearing, may censure him, or may suspend or expel any member of the

American Medical Association from AMA membership only for an infraction of the Constitution or these Bylaws or for a violation of the Principles of Medical Ethics."

### AMA Board of Trustees

The House approved a report of the Ad Hoc Committee on the Board of Trustees which recommended that the size of the Board of Trustees be increased from 11 members to 15 members. This will be accomplished by adding three elected members and by including the immediate past-president of the Association for a one-year term. The House also accepted a committee recommendation that set the term of office for elected Board members at three years and limited the number of terms to three, for a maximum total of nine years service. To implement the House action, the Council on Constitution and Bylaws submitted changes in the Constitution and Bylaws for consideration at the 1962 Clinical Meeting.

### Board of Abdominal Surgery Rejected

A study report from the Council on Medical Education and Hospitals, recommending that recognition **should not be granted to the American Board of Abdominal Surgery** as a specialty board, was approved by the House. In accepting the Council report, the House also declared its disapproval in principle of establishing specialties which are based largely or wholly on an arbitrarily defined anatomical region of the body.

The study, which was carried out under instructions from the House of Delegates at the 1961 Clinical Meeting, concluded that the present contribution of the American Board of Abdominal Surgery to the advancement of surgery and the betterment of public health is inadequate in many important respects. It also concluded that the American Board of Abdominal Surgery does not offer significant potential for the advancement of surgery and the betterment of public health.

### American College of Surgeons

In considering a Board report and four resolutions involving surgical assistants and relations between the AMA and the American College of Surgeons, **the House declared that the adoption and interpretation of the Principles of Medical Ethics is the prerogative and duty of the American Medical Association.** It also restated the Association's June, 1961, policy statement in the following manner:

"(1) Each member of the AMA is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"(2) Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"(3) No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

"(4) When services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately whenever possible.

"(5) It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance. This principle applies whether or not an assisting physician is the referring doctor."

### Voluntary Health Insurance

**In accepting a Council on Medical Service report** on the utilization of state and federal tax funds to provide voluntary prepayment health insurance protection to assist the aged in meeting the costs of health care services, the House approved the following policy statement:

"1. The need for application of the prepayment or insurance principle to protect our people against the costs of medical care is fully recognized and applies to all ages rather than to the aged alone.

"2. Persons financially able to prepay their own expenses are expected to do so and must be encouraged rather than compelled to do so.

"3. Persons financially unable to prepay adequately their expenses may properly be assisted to the degree necessary by their families, their communities, their states, and if these fail, by the Federal Government — but only in conjunction with other levels of government.

"4. The prepayment system should be devoid of governmental controls.

"5. Dignity and self-sufficiency for the individual should be upheld.

"6. The protection offered must be reasonably comprehensive rather than token in character."

The House recommended that the Board of Trustees and the Council on Medical Service explore all possibilities, using these principles as a basis.

### Revision of Education Council

Three resolutions, No. 5, No. 6 and No. 41, dealing with proposed revisions in the make-up of the Council on Medical Education and Hospitals, were introduced. Resolution No. 5 was presented by Dr. Budd, Ohio delegate, for the Ohio State Medical Association and was based on action taken in May by the OSMA House of Delegates. It advocated creating two councils — one for undergraduate medical education and another for graduate medical education. The be-it-resolved sections of the resolution read as follows:

"BE IT RESOLVED, That the House of Delegates of the American Medical Association instruct the Board of Trustees to initiate the proper steps to create two councils to replace the present Council on Medical Education and Hospitals — these to be known

as (1) The Council on Undergraduate Medical Education and (2) The Council on Graduate Medical Education — each to have functions logically falling within the areas described in the title, and further,

"BE IT RESOLVED, That each of the Councils should consist of ten members plus staff. The membership of the Council on Undergraduate Medical Education should consist of no more than eight members of medical school faculties and the membership of the Council on Graduate Medical Education should consist of no more than four members of medical school faculties.

Acting on the Ohio resolution, the Reference Committee on Medical Education and Hospitals, said:

"Your reference committee has carefully studied Resolution No. 5 and listened to the discussion thereon. It is the opinion of your reference committee that inasmuch as education is in itself an integrated process, the creation of two councils, as proposed in the resolution, **should not be approved.** That portion of the resolution which deals with the composition of the Council will be considered under resolution No. 6." **This portion of the reference committee report was approved.**

### Referred To Trustees

Regarding Resolution No. 6 from Missouri, the reference committee commented as follows:

"Your reference committee believes it important that members of the Council understand the needs of the private practice of medicine and the community hospitals in which it functions. In particular, the Council should appreciate the proper role of the non-university hospital for intern and resident training."

"Therefore, your reference committee submits the following as a substitute for Resolution No. 6.

"Resolved:

"(1) That at least six members of the Council shall be engaged primarily in the private practice of medicine in hospitals that do not have a medical school affiliation.

"(2) That no more than four members may be salaried personnel of a medical school or university.

"(3) That in the selection of all individuals as nominees for election to Council membership, deliberate care shall be exercised to assure that those selected understand and are sympathetic to the medical needs of the public."

**The motion of the committee that the substitute resolution be approved was not adopted but in lieu thereof the House of Delegates adopted a motion that the proposal be referred to the Board of Trustees for consideration.**

The Texas resolution No. 41, similar to the other two, was withdrawn.

### Miscellaneous Actions

In considering reports and resolutions on a wide variety of additional subjects, the House also:

Learned that the Board of Trustees has instructed the Council on Drugs to conduct a study on the relationship between **tobacco and disease.**

Approved a resolution that **honorariums** be provided for the Association's elected officers in amounts to be determined by the Board of Trustees.

Adopted an AMA Statement of Principles on **Mental Health** and urged all constitute associations to lend active support to the First National Congress for Mental Illness and Health, to be held in Chicago in October.

Endorsed a resolution on **employment of the handicapped,** stating that each individual candidate for employment should be evaluated in light of his ability to perform useful work.

Approved a Guide to the Organization and Operation of **Airport Medical Services** submitted by the Council on Occupational Health.

Endorsed the joint statement on **narcotic addiction** by the AMA and the National Research Council of the National Academy of Sciences.

Urged automobile manufacturers to make **seat belts,** approved by the Society of Automotive Engineers, standard equipment on all automobiles.

Recommended that the Council on Medical Education and Hospitals conduct a study of **specialty residencies.**

Reaffirmed its opposition to **compulsory coverage of physicians** under the Social Security Act, after receiving 11 resolutions opposing coverage and only two favoring the inclusion of physicians.

Accepted the report of the **Committee on Communications** as information, and, in considering the committee recommendations, suggested that the Executive Vice-President present a report of Association activities to the House at each meeting.

### Awards Presented

The AMA presented a special citation to Jackie Cooper, star of television, stage and movies, for his portrayal of a Navy doctor in the "Hennessey" television program.

The 1962 Joseph Goldberger Award in clinical nutrition was presented to Dr. Edwards Albert Park of Baltimore for his investigations of rickets and scurvy in children.

Dr. Larson received a plaque for his work on the medical advisory board of the Sears-Roebuck Foundation.

The American Medical Association was given awards of appreciation from the Cuban Medical Association in Exile and the Girl Scouts of America.

Donald D. Van Slyke, Ph. D., research chemist at the Brookhaven National Laboratories, received the first AMA Scientific Achievement Award honoring

outstanding contributions to medicine by non-physician scientists.

Mrs. George Papanicolaou was given a special award honoring her late husband's service to mankind.

### Ohio Exhibits Receive Honors

An exhibit, distinguished as outstanding at the Ohio State Medical Association Annual Meeting in Columbus, was honored also at the Annual Session of the American Medical Association. The scientific exhibit, "Spectrum of Clinical Cytology," in the Section on Pathology and Physiology, was awarded a Certificate of Merit at the AMA meeting. The exhibit sponsored by Dr. Emmerich von Haam, Ohio State University College of Medicine, and the National Institutes of Health, also received a Certificate of Merit at the OSMA meeting. Refer to page 825 of the July issue.

Two other Ohio exhibits were honored at the AMA Session. Honorable mention went to the exhibit "Artificial Heart Inside the Chest," sponsored by Drs. W. J. Kolff, Tetsuzo Akutsu, Velimer Mirkovitch, Karl Mohr, and Stephen R. Topaz, of the Cleveland Clinic, in the AMA Section on Experimental Medicine and Therapeutics.

Honorable mention also went to the exhibit, "Treatment of Lymphedema of the Arm," sponsored by Drs. Richard C. Britton and Paul A. Nelson, Cleveland Clinic Foundation, in the AMA Section on Preventive Medicine.

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### Former Ohioan Accepts California Post

Dr. John D. Porterfield, former Ohioan, and now deputy U. S. Surgeon General, has announced that he has accepted an appointment as coordinator for University of California Health and Medical Affairs.

Dr. Porterfield formerly was director of the Ohio Department of Health and later director of the Ohio Department of Mental Hygiene and Correction. He accepted the Washington appointment and left Ohio in 1956.

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### Ohio State Radiological Society Elects

At its recent annual meeting in Akron, the Ohio State Radiological Society elected and installed officers. Following are the officers for the year: President, Dr. Paul D. Meyer, Columbus; President-Elect, Dr. Delbert Russell, Elyria; Secretary, Dr. Chapin Hawley, Cincinnati; Treasurer, Dr. Charles Miller, Jr., Akron.

The 1963 meeting will be held in Dayton during the month of May.

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Ohio State University College of Medicine has been presented a gift of $35,000 from Wyeth Laboratories for use in instituting a program of television teaching.

# Do You Know? . . .

Dr. Lewis W. Cellio, Columbus, has been re-elected vice-speaker of the policy-making congress of delegates of the American Academy of General Practice.

* * *

Dr. George H. A. Clowes, associate professor of surgery at the Western Reserve University School of Medicine, has been appointed chairman of the department of surgery at the Medical College of South Carolina.

* * *

Dr. Earl H. Baxter, Ohio State University professor and chairman of the Department of Pediatrics, has been installed as president of the Medical Alumni Association of Ohio State's College of Medicine.

* * *

Dr. Charles D. Aring, Cincinnati, was installed president of the American Neurological Association at its annual convention in Atlantic City.

* * *

Dr. Paul R. Miller was recently named 1962 Columbus Father of the Year. Dr. Miller recently returned from Saigon where he served as a teaching physician on the S. S. Hope.

* * *

Dr. C. C. Landen, Columbus, recently walked off with Queen of Show honors at the Columbus Rose Club's 24th annual rose show. Dr. Landen won the prize with a Crimson Glory hybrid tea rose.

* * *

Dr. Dieter Koch-Weser, associate professor of medicine at Western Reserve University, has resigned to take over as chief of the new U. S. National Institutes of Rio de Janeiro, Brazil.

* * *

Dr. Walter J. Zeiter of Cleveland has become director of education of the Frank E. Bunts Educational Institute of Cleveland Clinic Foundation. Dr. Zeiter succeeds Dr. Charles L. Leedham, who has resigned to accept another position.

* * *

Dr. William A. Altemeier of the University of Cincinnati medical center has been honored by the Wayne State University and Detroit Surgical Association with the Theodore Andrews McGraw Medal.

* * *

Dr. William H. Benham, associate director of the Toledo Hospital school of medical technology, has been chosen president-elect of the Ohio Society of Pathologists.

* * *

Dr. Charles A. Anderson, Warren, has been elected president general of the National Society of the Sons of the American Revolution.

# Western Reserve Expansion Program...

## Schools of Medicine, Nursing and Dentistry Included in Expansion Plans of University Medical Center Complex

AN EIGHT-YEAR DEVELOPMENT program for the University Medical Center has been announced by the Boards of Trustees of University Hospitals of Cleveland and Western Reserve University.

The venture is the first combined Development Program undertaken by the University Medical Center composed of the Hospitals and WRU's Health Science Schools (Medicine, Nursing and Dentistry).

It was recommended to the boards of both institutions by a Joint Trustee Committee formed four years ago.

### What Program Will Do

In presenting the program, the Committee said its completion will provide the facilities which will enable the Hospitals and the three schools to meet existing needs and provide for projected requirements of the future. The program will:

1. Enable WRU to increase student classes to answer the need for educating more physicians, nurses and dentists, not only as practitioners, but also as researchers and educators;

2. Permit the faculty, staff members and student body to carry out research programs in adequate quarters;

3. Create the facilities which will provide the Hospitals with the flexibility needed to meet the changing health care needs of a growing population.

Included in the construction plans are two additions to the Medical School, a new Dental School and Clinic, a new Nursing School, three new hospital units, an addition to Hanna House, and extensive renovation of Lakeside and Babies and Childrens Hospitals, the Medical School and the Institute of Pathology.

*(See pictures on Front Cover.)*

The Joint Trustee Committee estimated the cost of the construction projects at $44,800,000. It also recommended that a $10,000,000 Facility Endowment Fund be established to maintain and operate the new facilities.

The new academic facilities will enable the School of Medicine to increase its enrollment by 20 per cent, the School of Dentistry by 30 per cent and the Frances Payne Bolton School of Nursing by 100 per cent.

### Projects Planned

Projects planned for the Health Science Schools of Western Reserve University will cost an estimated $20,000,000. They are:

- Construction of an East Wing on the School of Medicine consisting of an underground facility for Anatomy classes, and a four-story addition above ground housing a Health Science Library and student laboratories for teaching and research ($7,790,000);
- Construction of a four-story addition on the South Side of the Medical School to house the Departments of Developmental Biology and Biophysics ($1,230,000);
- Major renovation of the School of Medicine to provide expanded teaching and research facilities ($4,980,000);
- Remodeling and expansion of the Institute of Pathology ($500,000);
- Construction of a new School of Dentistry and Dental Clinic to replace the 45-year-old building currently in use ($4,000,000);
- Construction of a new School of Nursing replacing three 70-year-old converted private homes now being used ($1,500,000).

Improvements planned for University Hospitals of Cleveland will cost an estimated $24,000,000. They are:

- Construction of a General Patient Service Unit with two stories above ground and two below to house the Departments of Surgery, Radiology, and Physical Medicine and Rehabilitation. It also will provide additional space for such services as the dietary, accounting and medical records departments ($8,520,000);
- Construction of a three-story Ambulatory Care Center adjacent to Lakeside Hospital. It will serve as a central location for physicians' offices, examining rooms, diagnostic services and treatment areas for walk-in patients ($5,100,000);
- Construction of a five-story unit connected to the North side of Babies and Childrens Hospital and modernization of Babies and Childrens. This will

*(Continued on Page 938)*

# Proposed New Buildings in Expansion Program



*A six-story addition will be built on the north side of Hanna House at a cost of $1,010,000 to provide more office and conference rooms and permit a rearrangement of nursing stations and certain supporting services for greater efficiency.*



*The Frances Payne Bolton School of Nursing will be built at a cost of $1,500,000 and will be located in the area between the new School of Dentistry, the East Wing of the School of Medicine and the Ambulatory Care Center.*

## AMA Congress on Mental Illness. Oct. 4 - 6

The American Medical Association will hold its first National Congress on Mental Illness and Health in Chicago, October 4 - 6, with the cooperation of the American Psychiatric Association and the support of the National Association for Mental Health.

Participants will meet in both topical and regional discussion groups to develop coordinated and continuing mental health programs to be carried out at the national, state and local levels.

The topical meetings at the Congress will cover 21 subjects including research, hospital and community programs, personnel recruitment and physician education. Material developing from these discussions will then be brought up in the regional workshops. This format allows participants to first consider problems of special interest, decide on priorities for subsequent action in their state or region and then transform these considerations into positive programs tailored to the needs of their particular geographic area.

The American Medical Association hopes that as many physicians and interested citizens as possible will take part in the Congress.

More detailed information on the Congress and copies of the AMA mental health program can be obtained from the Council on Mental Health, American Medical Association, 535 N. Dearborn Street, Chicago 10, Illinois.

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## Western Reserve

*(Continued from Page 936)*

permit the facilities of Rainbow Hospital, now located in South Euclid, to be moved to the Medical Center area and will result in creation of a complete child-care center ($4,520,000);

- Construction of a six-story addition to Hanna House to provide more office and conference rooms and permit a rearrangement of nursing stations and certain supporting services for greater efficiency ($1,010,000);
- Complete modernization of the facilities of Lakeside Hospital. This will include rearrangement of all 16-bed wards to permit many improvements in patient comfort and efficiency of care in keeping with today's standards ($5,650,000).

Preliminary plans for some of the proposed facilities already have been completed. The start of construction has been tentatively scheduled for the Spring of 1963.

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A check for $20,000 for eye research was recently presented to Dr. Charles I. Thomas, director of the department of ophthalmology at University Hospitals, Cleveland, by the Ohio Lions Clubs.

## Ohio Surgeons Schedule Program In Youngstown. Sept. 14-15

The seventh annual meeting of the Ohio Chapter of the American College of Surgeons will be held Friday and Saturday, September 14-15, at the Hotel Pick-Ohio, Youngstown. Sections represented will be General Surgery, Urology, Neurosurgery, and Obstetrics and Gynecology.

Discussion of current trends in the management of melanoma, "How I Do It" clinics and presentation of papers by the winners of the Resident Essay competition, will feature the opening morning session on Friday. Dr. George W. Stephenson, assistant director of the College, will lead the discussion of current trends in graduate training in surgery in community hospitals, following luncheon.

Friday afternoon session will include panel discussions on current trends in the management of gastroduodenal, procto-colonic and pediatric problems. A symposium on current trends in treatment of burns and their complications will conclude the afternoon program.

On Friday evening a cocktail hour and dinner will be held, followed by entertainment.

Sections will meet on Saturday morning, after which the entire group will hear a panel discussion on Current Trends in the Management of Advanced Carcinoma, to be moderated by Dr. George T. Pack of New York.

Dr. Frank Shively, Dayton, is Chapter president, and Dr. Tom Lewis, Columbus, secretary. Dr. Stanley O. Hoerr, Cleveland, will be installed as incoming president during the business meeting Friday afternoon. Dr. Stephen W. Ondash, Youngstown, is State chairman. Executive committee for the meeting arrangements includes Drs. Oscar Turner, Fred Schlect, A. K. Phillips, J. J. McDonough, Gordon Nelson, William Flynn and Robert McConnell.

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### New Name Given to Education Institute in Cleveland

The Board of Trustees of The Cleveland Clinic Foundation announced a change of name for The Frank E. Bunts Educational Institute, the educational affiliate of the patient-care, teaching and research institution.

The institute, named after one of the four founders of The Cleveland Clinic Foundation, will now be known as the Cleveland Clinic Educational Foundation. The name of Dr. Bunts, as well as the names of the other three founders, will be perpetuated in other ways by the educational unit.

In making the announcement, Dr. Walter J. Zeiter said that the new name better identified the educational portion of The Cleveland Clinic Foundation's work.

# Polio Vaccine Programs in Ohio . . .

## Unprecedented High Level of Population Immunized As Many County Medical Societies Back Campaigns

MEDICAL societies, large and small, have taken the leadership in county campaigns throughout Ohio conducted for the purpose of eliminating poliomyelitis from the State. Local programs, practically all under medical society sponsorship, blossomed during the early months of 1962; multiplied throughout the spring; continued throughout the summer. Many county programs were held over until Fall, with plans for completion during the winter months.

Practically all the county campaigns involved the Sabin oral vaccine with Types I, II, and III used in various rotations, depending upon the availability of the strain in the given area.

An analysis of news reports on these activities throughout the state shows that in most cases the cost of the programs has been guaranteed by the medical society and financed with donations of twenty-five cents, sometimes more, voluntarily contributed by the recipients of the vaccine.

Population coverage with the vaccine reached unprecedented levels, with official midsummer tabulations from Cuyahoga County reaching 94 per cent of the county's population on the first round of the vaccine.

The "Sabin Oral Sunday" program in Cuyahoga County, sponsored by the Cleveland Academy of Medicine, has attracted nationwide attention.

The Academy is the sponsor of the program, and is using a general organization consisting of: Chairman, Co-chairman, Coordinator, Steering Committee, with Subcommittees as follows: Sites, Supplies, Manpower, and Publicity.

The Academy is being assisted by thirteen to twenty thousand allies, including nurses, Red Cross workers, Parent-Teacher Association members, pharmacists, boy and girl scouts, Junior Chambers of Commerce members, bankers, Kiwanians, osteopaths and dentists.

Each clinic site has been manned by two doctors of medicine. The Academy of Medicine increased its liability insurance. Each physician is covered by his own malpractice insurance in his work on the project.

### Muskingum County Program

Another remarkable accomplishment, and one of the early Ohio Sabin programs is the one sponsored jointly by the Muskingum County Academy of Medicine and the Muskingum Valley Academy of Pharmacy.

At the request of the Ohio State Medical Association, Dr. Benjamin W. Gilliotte, Zanesville, Secretary of the Muskingum County Academy of Medicine, has submitted details regarding the operation of the program. Excerpts from his statement appear below:

### Administration of the Program

The program was administered jointly by a committee from the academy and one from the county pharmaceutical academy, under the sponsorship of the two academies. A physician was appointed as chairman of the over-all committee. He appointed various subcommittees which were composed of both physicians and pharmacists to work out the details. The committees were as follows, Public Relations, Financial, Supplies, and Personnel.

### Finances

It was decided at the outset that no charge would be made for the vaccine, but that a contribution of 25¢ or more would be suggested. No one was refused the vaccine because of inability to pay. The average contribution was about 28¢ which paid for the vaccine and incidental expenses, and left a surplus when the program was completed. This surplus is to be used to give booster doses of the vaccine in future years.

### Legal

Since no actual charge was made there was no implied warranty of the product. A form was signed by each person taking the vaccine which gave permission. In the case of minors, the parent was required to sign the permit. A physician was in charge of each immunization center and was legally responsible for the vaccine administered at his center during his particular shift. The Academy did not take out any special insurance policy for the physicians or pharmacists, but felt that the individual professional liability insurance already carried would be adequate.

### Public Relations

Several meetings were held with representatives of the press, radio, and television media. These were informal meetings, usually at lunch. Question-and-

## Make a Note of September 26 — Last Day To Register In This All-Important General Election Year

November 6 is the General Election, a Red Letter Day in the life of every patriotic citizen. Yet an equally important day to many potential voters is September 26, the last day on which a voter may register to vote, if he is not already qualified.

You must register to vote IF:

You reside in a registration territory and (1) have not voted at least once in the past two calendar years; (2) have moved since you registered; (3) have changed your name.

Any person who is in doubt as to his eligibility to vote should contact the County Board of Elections to determine his status.

Every patriotic citizen would do well to determine that he, members of his family and patriotic friends are eligible to vote in the November 6 General Election.

answer periods were on the television station on several occasions, numerous articles appeared in the paper daily during the final week before each type was given, and the radio used taped interviews with physicians and pharmacists at intervals throughout the days preceding. Pictures were taken of the immunization stations in action. Cardboard posters were printed which had information regarding the dates, times, and places of administration of the vaccine. These were posted in various business place windows over the county.

Flyers were printed and one physician dropped these from his airplane at various points in the city.

The motto of the program was, "Three Days — Three Drops — Polio Stops." This was coined by the director of the radio-TV station. This theme was carried out on all of the literature.

Brochures were printed which explained in lay terms the reasons for the vaccine, its safety, etc. These were distributed through physicians' offices and the pharmacies, as well as to all of the school children in the county.

### Kits

A large basket was obtained for each immunization center. In the basket was placed all the supplies needed for each station. A partial list of supplies follows: Permit blanks, pencils, paper cups, distilled water, medicine droppers, money bag money wrappers, fishbowls (for donations) and posters.

This was packed the night before each day of administration of the vaccine. The vaccine itself was thawed, and mixed by the pharmacists, the day of administration.

### Operation of a Center

A physician was in charge of each center. One pharmacist was present and mixed the vaccine and was responsible for the money collected. The physician had an overall responsibility for the operation of the center, and made decisions as to whether or not the vaccine should be given to a particular person.

A woman captain was in charge of the non-professional personnel at each center. In most cases this was a physician's wife or a pharmacist's wife. Assisting her were the following persons: four ushers (usually teen-age students) and from four to six clerks, depending on the size of the center. At least two nurses were present at most stations and administered the vaccine.

All workers were on a voluntary basis, and no one connected with the program received any remuneration.

### Future Plans

With the surplus money that accrued, the organization decided to continue the program by giving booster doses when indicated, and further initial doses as indicated. However, the physicians were encouraged to administer the vaccine as much as possible in their offices on a private patient relationship.

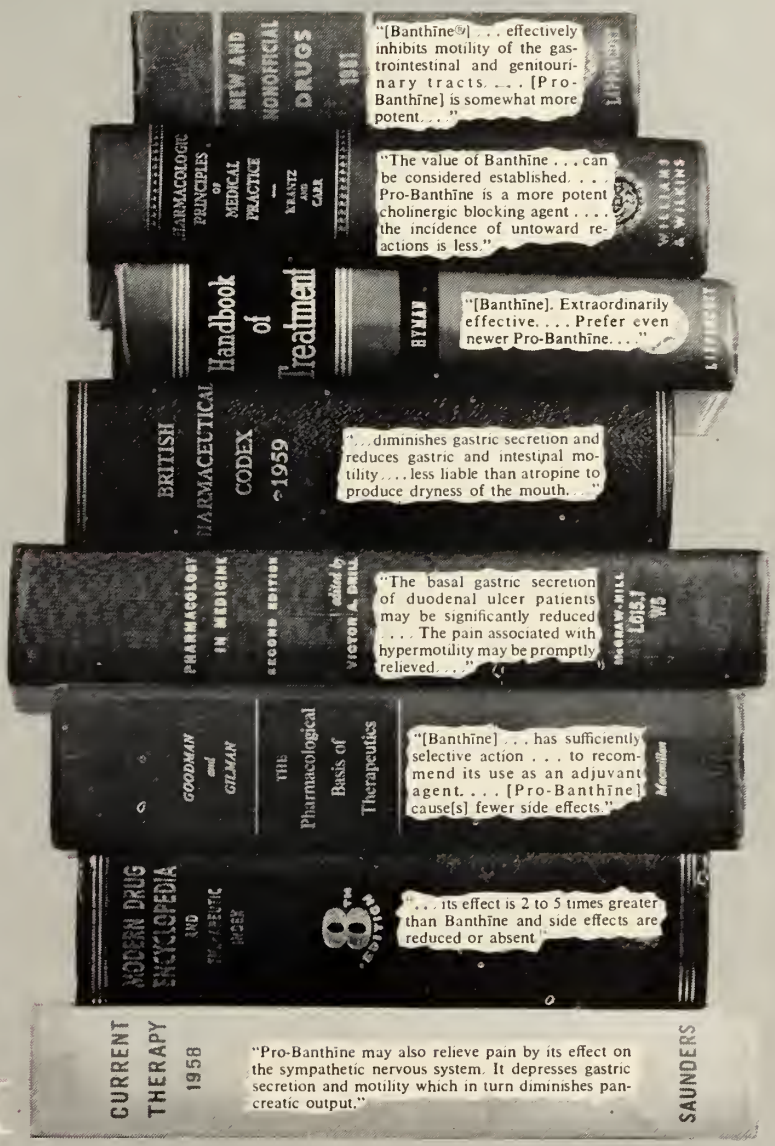
### Reactions

After each phase of the program the physicians received numerous calls, alleging that "I took the vaccine yesterday, now I have a cold," etc. These complaints were all found to be unrelated to the vaccine, and were diplomatically treated. No reaction of any kind was definitely attributed to the vaccine. About 60 per cent of the county population received the vaccine.

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## Review on 544 Drugs

Detailed information on 544 new single chemical entities, introduced in the past two decades and on the United States market today, is contained in *Review of Drugs, 1941-1961.* The 50-page compendium, the first of its kind anywhere, was released June 29 by the Pharmaceutical Manufacturers Association of Washington, D. C. Copies are available from that office.




by the book

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# Athletic Injury Institute . . .

## Jointly Sponsored Program Scheduled On Ohio State Campus August 29-30

A POSTGRADUATE Institute for Physicians on Medical Aspects of High School Athletics will be held on Wednesday and Thursday, August 29-30, on the College of Medicine Campus, Ohio State University, Columbus.

The Institute will be sponsored by the Ohio State Medical Association, the Ohio State University College of Medicine and the Ohio High School Athletic Association.

The Institute will include short papers, panel discussions, and demonstrations. The wide range of topics includes prevention and treatment of medical, surgical and dental conditions, special protective equipment and its use, first aid and emergency decisions on the field, and the emotional problems of young athletes.

Fee for the course, $20, will cover two luncheons, a reception the night of August 29, campus parking and incidentals. Registration and inquiries may be sent to Mr. Hart F. Page, Institute Treasurer, c/o The Ohio State Medical Association, 79 E. State Street, Columbus 15, Ohio.

Institute registrants must make their own hotel reservations. A block of rooms has been set aside at the Ohio Stater Inn, 2060 N. High St., Columbus 1, Ohio, the location of the August 29 reception.

### WEDNESDAY MORNING, AUGUST 29

Presiding: Charles H. McMullen, M. D., Loudonville

9:00 A.M.—Registration

9:30—Welcome

Richard L. Meiling, M. D.,
Ohio State University College of Medicine

Geo. J. Hamwi, M. D.,
Ohio State Medical Association

9:45—**Panel Presentation — On-the-job Viewpoints of Medical Aspects of High School Athletics**

Administrator
Walter Heischman, Upper Arlington

Coach
Bron Bacevich, Cincinnati

Team Physician
Charles H. McMullen, M. D., Loudonville

10:30—Coffee Break

10:45—**Panel Presentation**

(1) **Qualifications for Participation in Athletics**
Thomas E. Shaffer, M. D., Columbus

(2) **Medical Problems in Athletics**
Robert J. Murphy, M. D., Columbus

(3) **Field Decisions**
Ernest R. Biggs, Columbus

11:45—**Emotional Aspects of High School Athletics**
W. Hugh Missildine, M. D., Columbus

12:00—Lunch

### WEDNESDAY AFTERNOON, AUGUST 29

Presiding: Angus E. King, Cincinnati

1:30 P.M.—**Report of the Commissioner**
William J. McConnell, Columbus

2:00—**The Physician as Trainer**
Allan J. Ryan, M. D., Meriden, Connecticut

3:00—**Management of Common Athletic Injuries**
Richard Patton, M. D., Columbus

4:00—Question and Answer Period
Drs. Ryan, Murphy, Patton and Shaffer

5:30—Social Hour—Ohio Stater Inn

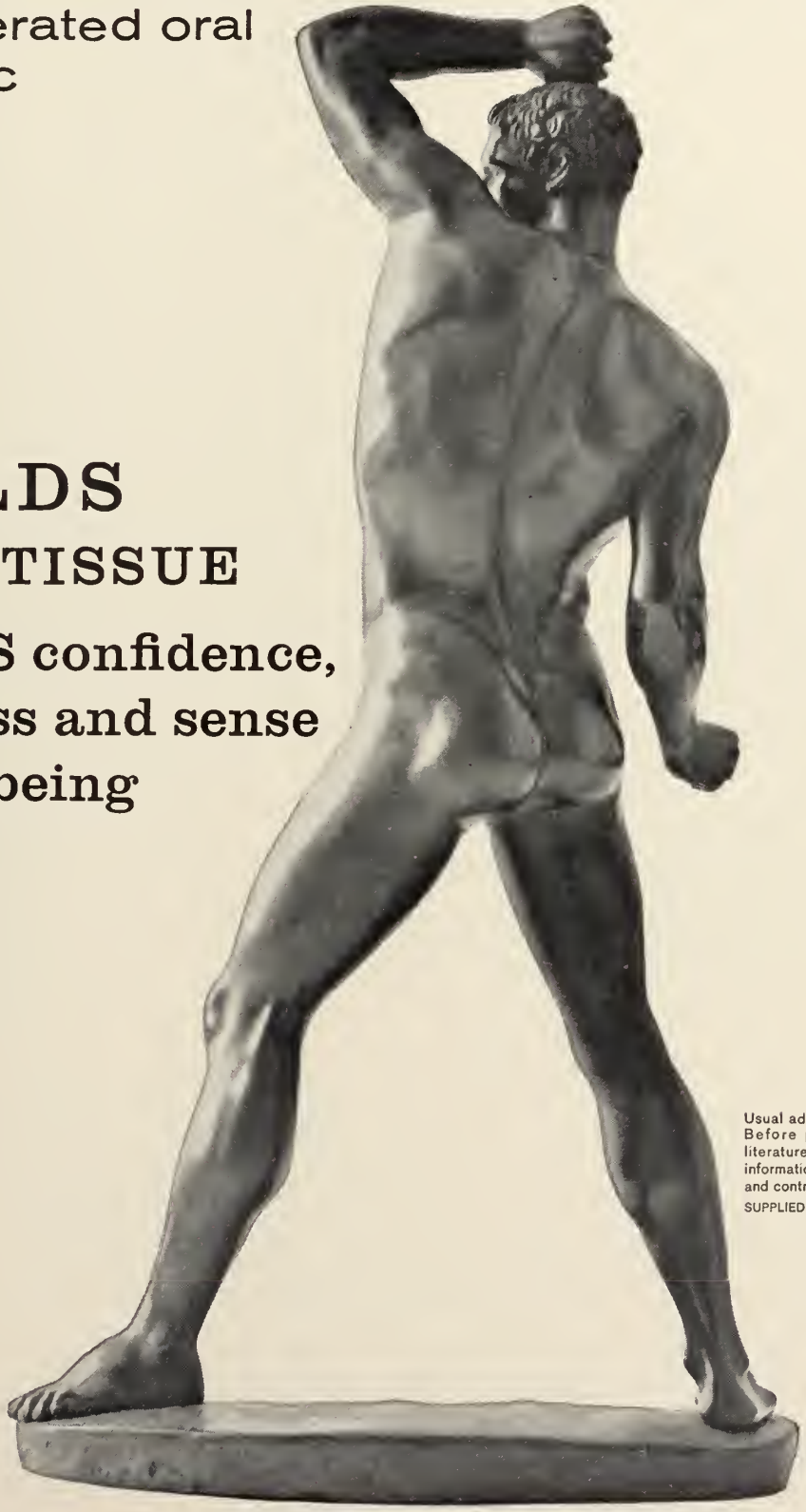
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REGISTRATION: Postgraduate Institute on Medical Aspects of High School Athletics

NAME .....M.D.

ADDRESS .....

.....

APPLICATIONS MUST BE RECEIVED BY AUGUST 15

Make checks payable and
Mail to: Hart F. Page, Institute Treasurer
Ohio State Medical Association
79 E. State Street, Columbus 15, Ohio

Fee Enclosed ($20) includes Reception at Ohio Stater Inn .....

EXTRA

Reception (per guest) tickets $3.00 .....

Total Enclosed .....

## THURSDAY MORNING, AUGUST 30

The Ohio State University Stadium

Presiding: Robert J. Murphy, M. D., Columbus

9:00 A.M.—**Conditioning Drill and Blocking Techniques (Stadium)**
Coach W. W. Hayes and Staff, Columbus

10:15—**Booth Seminars (Stadium Training Rooms)**

(1) **Dental Protection**
Wm. D. Heintz, D. D. S., Columbus

(2) **Contact Lenses**
R. H. Magnuson, M. D. and Joseph L. Bitonte, B. E. E., Columbus

(3) **Taping**
Ernest R. Biggs and Staff, Columbus

(4) **Standard Protective Equipment**
Ernest R. Biggs and Staff

(5) **Special Protective Equipment**
Richard Patton, M. D., Columbus

(6) **Prevention of Head and Neck Injuries** (Headgear; Neck Conditioning)
Ernest R. Biggs and Staff

12:00—Lunch

## THURSDAY AFTERNOON, AUGUST 30

Presiding: John A. Prior, M. D., Columbus

1:45 P.M.—**Orthopedic Problems in Adolescence**
Judson D. Wilson, M. D., Columbus

2:15—**Head Injuries**
Martin P. Sayers, M. D., Columbus

2:45—**Neck Injuries**
William E. Hunt, M. D., Columbus

3:15—Question and Answer Period

3:30—Adjournment

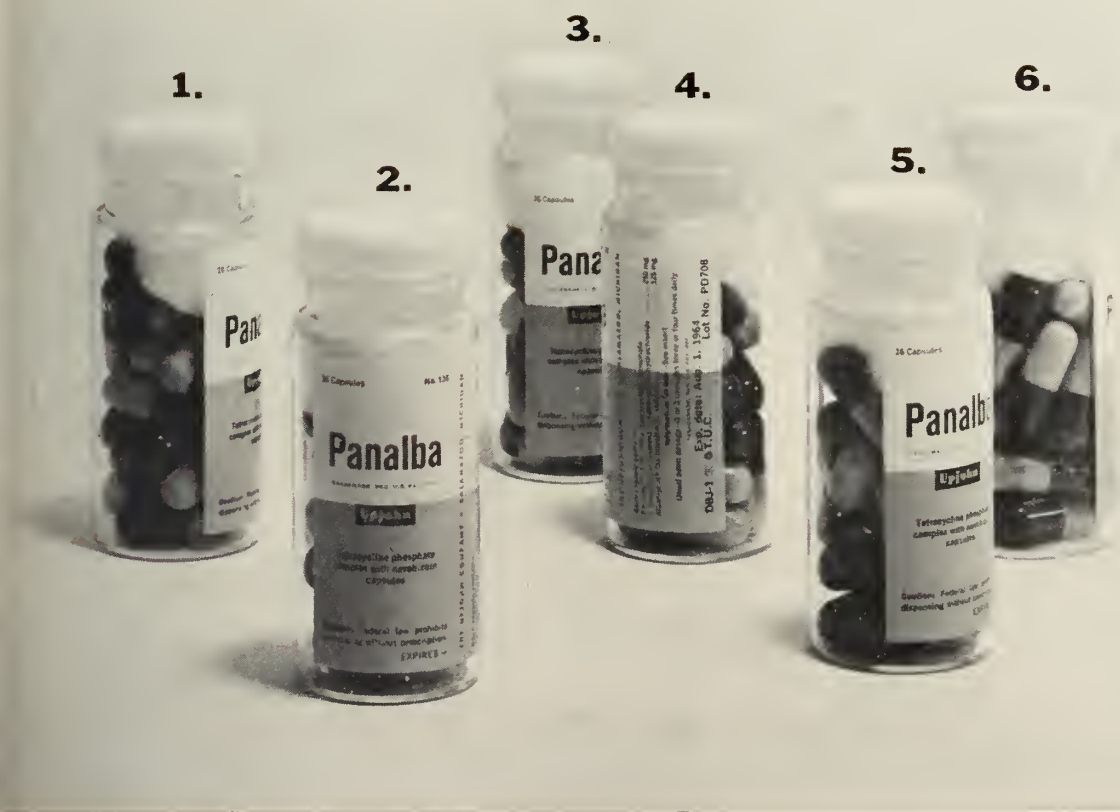
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### Five Ohio Hospitals Given Federal Grant Funds

Hospitals in Akron, Barnesville, Ravenna, Toledo and Zanesville were given a total of $2,473,889 in Federal funds in April and May through the Federal Hospital Survey and Construction Act, administered by the Public Health Service.

Here's how the money was distributed in Ohio: St. Edwards Nursing Home, 101 nursing home beds, Akron, $448,871; Barnesville Hospital, 26-bed addition, Barnesville, $95,000; Robinson Memorial Hospital, diagnostic and treatment facilities, Ravenna, $89,475; Flower Hospital, surgical suite, Toledo, $150,000; Bethesda Hospital, 208 beds, Zanesville, $1,690,543.

The total cost of the improvements was $7,688,685 with federal funds amounting to about one-third of the total.




**1.** ***In otitis media*** **2.** ***In pyoderma***
**3.** ***In laryngopharyngitis***
**4.** ***In bacterial pneumonia***
**5.** ***In bronchiectasis*** **6.** ***In osteomyelitis***

In these and other bacterial infections, give Panalba* in addition to the usual surgical or other appropriate therapeutic measures. *From the outset,* pending laboratory determinations, your treatment broadens in antibacterial coverage because of the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

Panalba combines tetracycline (selected for its breadth of coverage) and novobiocin (selected for its unique effectiveness against staph). That is why, in most infections of unknown etiology, Panalba offers excellent chances for therapeutic success.

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# Disaster Medical Care . . .

## OSMA Sponsored Program Held in Columbus



*Shown here is part of the 200-bed emergency hospital as it was set up at the Ohio State Fair Grounds in Columbus.*

THE first Disaster Medical Care Conference designed to inform the physicians of Ohio concerning their role in cases of crisis was held June 17 at the Arts and Crafts Building, Ohio State Fairgrounds, Columbus. Some fifty physicians attended the one-day program sponsored by the Ohio State Medical Association Committee on Disaster Medical Care.

Following opening remarks by Geo. J. Hamwi, M. D., President of O. S. M. A., Dr. Carruth J. Wagner, Chief of the Division of Health Mobilization, Office of the Surgeon General, U. S. P. H. S., explained "County Organization for Disaster Medical Care" and told of the physician's role in this activity. Dr. Wagner placed much emphasis on the importance of physician participation to the success of a disaster program.

Dr. Wendell A. Butcher, chairman of the OSMA Committee on Disaster Medical Care, then discussed "Newer Concepts of Nuclear Warfare and How They Affect Your County Program."

Following lunch, Dr. Vol K. Philips, chairman of the Committee on Disaster Medical Care of the Columbus Academy of Medicine, conducted a tour of a 200 bed emergency hospital at the fairgrounds. The men of the 449th General Hospital (USAR) Fort Hayes presented a training exercise in cooperation with the Red Cross and Civil Defense demonstrating the operation of an emergency hospital.



*Left, is Dr. Wendell A. Butcher, program chairman; and Earl O. Wright, chief of the Division of Administration, Ohio Department of Health, one of the principal speakers.*

Earl O. Wright, Chief of the Division of Administration of the Ohio Department of Health, discussed "Medical Self Helping Training —Role of the Physician and the County Medical Society." Mr. Wright explained the medical self help training kit which is available to those who wish to train others in medical self help.

As a conference wrap-up, a panel discussion was held on "Mutual Interdependence of Organizations in Medical Disasters." Participating in the discussion were George G. Dubach representing the Ohio Hospital Association, Edward R. Menders, representing the American National Red Cross, Alfred E. Diamond, Ph. D., representing Ohio Civil Defense, and Thomas D. Allison, M. D., member of the OSMA Committee on Disaster Medical Care.



*Key persons in the Disaster Medical Care program are shown, left to right: Dr. Wendell A. Butcher, chairman of the OSMA Committee on Disaster Medical Care; the Hon. W. Ralston Westlake, Mayor of Columbus; Dr. Geo. J. Hamwi, OSMA President; and Dr. Vol K. Philips, Chairman of the Columbus Academy's Committee on Disaster Medical Care.*

# Several New Important Rulings Voted by OMI Board

By R. DEAN DOOLEY, M.D.

Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

THE Executive Committee has approved some significant and far-reaching changes in OMI's methods of indemnifying the services of plastic surgeons. Plastic surgery had, perhaps, in the past, presented us with more problems than any other field of medical practice. This statement, in no wise, is meant to reflect on the plastic surgeons, but, rather, stems from the difficult task of judging claims based on the criteria of function. The experience of the past dictates a change and exemplifies the truth of the dictum, "The past serves as a good guidepost for the future but is dangerous if it is used for a hitching post." Though stated many years ago, it is certainly just as timely and appropriate today.

### Policies Established

Because of the constantly recurring problems associated with certain surgical claims, usually plastic in character, the Executive Committee, on the recommendation of the Medical Advisory Committee, directed management to amend related claim procedures so that coverage is extended to include claims for the surgical correction of conditions produced by trauma, infection, or neoplasm.

Management was further instructed to indemnify claims for the surgical correction of all congenital anomalies in subscribers up to the nineteenth birthday. In the first instance claims resulting from the revision of post-traumatic scars will be honored if they meet the above description. These claims in the past have been judged on the basis of function, which restriction excluded many in the category from indemnification. This addition materially liberalizes the coverage. In the case of congenital defects, many now considered as purely cosmetic and excluded, are now subject to benefit reimbursement.

### Getting Doctor's Statements

We are still confronted with the problem of obtaining doctors' statements in the cases of subscribers insured under contracts in which a doctor's statement is a condition of claim validation. I have written much on this subject and can say, it is my conviction, that Ohio Medical Indemnity has no choice than to follow the policy of requiring physicians' bills.

We are, in effect, the custodian of your funds and, if we fail to pursue a course calculated to effectuate our stewardship, we are guilty of dereliction. Since we have instituted this procedure, we have found many times physicians' charges have been substantially less than stated indemnities. I think there can be little argument that it is not our purpose to make money for our subscribers through claim liabilities they produce. Certainly, if our indemnity pays the entire professional charges, both we and the subscriber are happy; by the same token, we do not think we are obligated to pay more than the professional charges. We currently have five contracts which require a statement of physicians' charges and I believe I can confidently state that all new contracts in the future will contain the clause which states that in no wise will the benefit payment exceed the actual charges made by the attending physicians.

### Little Resistance

Surprisingly, we have found little resistance on the part of doctors to supplying us their charges. Because our claim form has no space for the indication of charges, and there is no way for the physicians to know which contract requires a statement of charges, we find we are frequently confronted with the task of obtaining the necessary information, first, through the subscriber and then, if unsuccessful, from the doctor. This involves long delays, correspondence, irritation to doctors, and is a very unwieldy and inefficient way to operate a program.

### New Claim Form

The Executive Committee also authorized the administration of Ohio Medical Indemnity to develop a new claim form in which there is space for the doctor to indicate his charges for services rendered. This is done now on the Federal claim form and we find, in areas in which the practice of submitting charges has become routine, there are no associated problems. We believe that such a claim form will be accepted by the profession and will save physicians many hours in correspondence and certainly will increase the efficiency and effectiveness of our operation.

# Workmen's Compensation . . .

## Fifth of a Series of Articles on the Ohio Program Shows Physicians How To Obtain Prompt Payment

THIS is the fifth in a series of articles being published in *The Journal* pertaining to the administration of the Ohio Workmen's Compensation Law, especially about procedures of special interest to physicians. Clip these articles for ready reference. Additional articles will be published. Watch for them. This month's article continues the summary of some of the general rules relating to medical services.

### Payment For Braces And Appliances

Fees for braces and other appliances are not approved unless written authority has been given in advance. Authorization is not required, however, for the first truss obtained immediately subsequent to injury in hernia claims.

### Evidence Needed In Lead Poisoning

Stained blood smears and a report of the percentage of urinary and/or blood lead should be submitted to the Medical Section as substantiating evidence in all claims filed for lead poisoning.

### Fee In Cases Previously Treated

If a physician receives a case in which the first treatment has been rendered in the emergency room of a hospital or by another physician he is entitled to the scheduled fee for "first treatment" for his first services.

### Estimating Period of Disability

In estimating the period of disability, the physician should be conservative. If it is found that the estimate is insufficient, a subsequent report may be submitted at any time.

### Amputation Reports Must Be Accurate

In cases involving amputations, the physician must mark the exact line of amputation on the diagram on the reverse side of form C-84. To avoid error the exact location of the amputation should be described in the written report and the marking and report should be carefully checked to be certain that they agree.

**Want A Speaker on Subject of Workmen's Compensation?**

The Bureau of Workmen's Compensation and the Industrial Commission of Ohio will be happy to provide a speaker on Workmen's Compensation, with special emphasis on fee bills, claims procedure and related subjects. Requests should be directed to: Mr. George H. Thompson, Chief Deputy Administrator, Claims Section, Bureau of Workmen's Compensation, Columbus 15, Ohio.

### How to Describe Fingers and Toes

Inasmuch as a different nomenclature is sometimes used in describing fingers and phalanges, the Bureau requests that for the purpose of uniformity the terminology given on the diagrams on the reverse side of the report forms be used in reporting amputations. It should be noted that the index finger is the first finger and the little finger is the fourth finger. The phalanges of the fingers are numbered first, second and third, beginning with the proximal phalanx, or, the proximal phalanx is designated as the first, and the distal phalanx as the third.

### Reports on Minor Details Important

In claims involving injury to more than one part of the body, care should be given to report all minor details. Although they may appear to be trivial at the time, they frequently become factors of major importance.

### Employment of Nurse Service

When the condition of the claimant clearly indicates the necessity for same, registered or licensed practical nurses may be employed without authorization for such period of time as may be necessary. Such care, however, must be shown to be definitely indicated on the physicians' and nurses' reports. Fees

for nursing services are not approved in hernia claims unless it is clearly shown that an unusual condition existed which required such services.

### Payment For Travel To Other Cities

Excepting for the first call, travel mileage will not be paid for trips to another city for home or hospital calls unless the necessity for same is fully explained.

### Fees Allowed For Unlisted Procedures

Fees for operations and procedures not listed in the fee schedules are approved at rates comparable to those established for similar procedures.

### When Payment For Glasses Is Allowed

In cases of an industrial accident which injures an employee also causes damage to the employee's eyeglasses while the same are in place on the employee's face, the Bureau will pay a reasonable sum to repair or replace such eyeglasses but does not pay for glasses or refraction to correct errors in vision resulting from injury.

### Claim Number Is Essential

When writing to the Bureau concerning a claim the physician always should give the claim number. Both the claimant and employer are given the claim number of claims involving lost time (form C-1, blue color) as soon as one has been assigned. The claim number of a claim involving medical fees only and no lost time (form C-3, pink color) is sent to the employer. If unable to get claim number, the doctor should submit name of claimant, name of employer and date of injury.

### Use Separate Letter On Each Claim

When reporting or requesting information on more than one claim the physician should use a separate letter for each claim, as all letters are placed in the individual claim file with material which pertains only to that claim. This suggestion will assure more prompt replies.

---

## Akron Doctors' Orchestra

The Doctors' Orchestra of Akron in June concluded its 36th session by giving its 244th concert before the Summit County Medical Society. Thirty-seven doctors make up the group with the following leaders: Dr. A. S. McCormick, director emeritus; Dr. R. P. Bragg, director; Dr. A. Dobkin, concertmaster, and Dr. H. Gartner, assistant concertmaster.

---

Dr. R. K. Bartholomew, Dayton, has been elected president of the Ohio State Heart Association.


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# Ad Astra

Wayne L. Agey, M.D., Youngstown; Ohio State University College of Medicine, 1948; aged 41; died June 27; member of the Ohio State Medical Association and the American Medical Association. A native of Youngstown, Dr. Agey returned there to practice after completing an internship in Columbus and doing graduate work at Henry Ford Hospital in Detroit. Affiliations included membership in the Lutheran Church, service on the board of the Mahoning Tuberculosis Sanatorium and on the board of the Adult Guidance Clinic. Survivors include his widow, two daughters, his father and a sister.

Charles Wason Burhans, M.D., Lakewood; Western Reserve University School of Medicine, 1915; aged 72; died June 14; member of the Ohio State Medical Association, the American Medical Association, American Pediatric Society and American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A physician of long standing in the Lakewood and Cleveland area, Dr. Burhans specialized in pediatrics. He formerly held appointment on the pediatrics faculty of Western Reserve and made frequent contributions to medical literature. A veteran of World War I, he is survived by his widow, a daughter, a son and two sisters.

Frank Joseph Doran, M.D., Lakewood; St. Louis University School of Medicine, 1919; aged 69; died June 28; member of the Ohio State Medical Association, the American Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. A native of Cleveland, Dr. Doran returned there after his medical training and practiced for many years on the West Side. A member of the Catholic Church, he is survived by his widow, a daughter and two sisters.

John James Maloney, M.D., Cincinnati; University of Cincinnati College of Medicine, 1921; aged 66; died June 15; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A native of Cincinnati, Dr. Maloney practiced there for about 40 years, specializing in surgery. He was a member of the Catholic Church. Survivors include his widow, two sons and two daughters.

George Henry Musekamp, M.D., Cheviot; University of Cincinnati College of Medicine, 1921; aged 64; died June 15; member of the Ohio State Medical Association and the American Academy of General Practice. A practicing physician in Cheviot and the Cincinnati area for about 40 years, Dr. Musekamp was a member of a physician family. His grandfather, great grandfather and great great grandfather, as well as two uncles were physicians. A veteran of World War I, he was a member of the American Legion. Other affiliations included membership in several Masonic bodies, and numerous community organizations. Surviving are his widow, a son and a sister.

John Louis Pruzzo, M.D., Dayton; St. Louis University School of Medicine, 1956; aged 34; died June 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Pruzzo's practice in the Dayton area included appointments on the staffs of St. Elizabeth, Miami Valley and Good Samaritan hospitals. He was a member of the Kettering Optimist Club and the Church of the Holy Angels. Survivors include his widow, three daughters and his mother.

William Earl Shrontz, M.D., Newark; Physio-Medical College of Indiana, 1906; aged 80; died June 26; former member of the Ohio State Medical Association and the American Medical Association. Dr. Shrontz practiced for many years in the Newark area before his retirement about five years ago. He was for many years physician for the local high school athletic activities and served as Licking County coroner. Surviving are his widow and a son.

Kirke R. Teachnor, M.D., Washington C.H.; Medical College of Ohio, Cincinnati, 1900; aged 86; died June 17; former member of the Ohio State Medical Association. Dr. Teachnor moved to Washington C. H. in 1939 after practicing for many years in Leesburg and Hillsboro. Among affiliations, he was a member of the Masonic Lodge and the Elks Lodge. Survivors include his widow and two sisters.

Ray Thomas Thomson, M.D., Cleveland, Western Reserve University School of Medicine, 1923; aged 69; died June 17; recent member of the Ohio State Medical Association. A career Public Health Service physician for many years, Dr. Thomson was on the staff of the Marine Hospital in Cleveland until the hospital was turned over to the state about five years ago. He later was associated with the Prudential Life Insurance Company. Surviving are his widow, a son, two brothers and a sister.

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## Roster of Specialty Sections And Their Officers

Closely associated with the OSMA Annual Meeting are the Specialty Sections which help to conduct programs in their respective fields. Specialty Sections usually hold a brief business meeting and elect officers. These officers with members of their respective Sections work with the State Association's Committee on Scientific Work and aid in planning next year's Annual Meeting program. Following are the names and addresses of these officers for the convenience of members who may wish to correspond with them:

Section on Anesthesiology — *Chairman,* Walter B. Wildman, M. D., 199 Lafayette Circle, Cincinnati 20; *Secretary,* Herman L. Allen, M.D., 402 Oak Hill Avenue, Youngstown 2.

Section on General Practice of Medicine — *Chairman,* Sol Maggied, M.D., 15 East Pearl Street, West Jefferson; *Secretary,* Morton E. Block, M.D., 226 Troy Street, Dayton 4.

Section on Internal Medicine — *Chairman,* Clayton R. Sikes, M. D., 47 East Hollister Street, Cincinnati 19; *Secretary,* Joseph K. Doran, M.D., 10515 Carnegie Ave., Cleveland 6.

Section on Nervous and Mental Diseases — *Chairman,* Philip E. Piker, M.D., Cincinnati General Hospital, Department of Psychiatry, Cincinnati 29; *Secretary,* Irwin N. Perr, M. D., Fairhill Psychiatric Hospital, 12200 Fairhill Road, Cleveland 20.

Section on Neurological Surgery — *Chairman,* Edgar S. Lotspeich, Jr., M.D., 506 Oak Street, Cincinnati 19; *Secretary,* Laurence M. Weinberger, M.D., 157 West Cedar Street, Akron 7.

Section on Obstetrics and Gynecology — *Chairman,* James H. Williams, M.D., 3545 Olentangy River Road, Columbus 14; *Secretary,* Roger B. Scott, M.D., 2105 Adelbert Road, Cleveland 6.

Section on Occupational Medicine — *Chairman* William F. Ashe, M. D., Ohio State University, Dept. of Preventive Medicine, 410 West Tenth Avenue, Columbus 10; *Secretary,* Joseph R. Paradise, M.D., 9333 Miles Avenue, Cleveland 5.

Section on Ophthalmology — *Chairman,* Torrence A. Makley, Jr., M. D., University Hospital, Room N-350, Columbus 10; *Secretary,* Jerome A. Gans, M.D., 1020 Huron Road, Cleveland 15.

Section on Orthopaedic Surgery — *Chairman,* Donald I. Minnig, M. D., 640 West Market Street, Akron 3; *Secretary,* Norman J. Rosenberg, M.D., 10900 Carnegie Ave., Cleveland 6.

Section on Otorhinolaryngology — *Chairman* Harold E. Harris, M.D., Cleveland Clinic, 2020 East 93rd St., Cleveland 6; *Secretary,* Gerson Lowenthal, M.D., 280 Doctors Building, Cincinnati 2.

Section on Pathology — *Chairman,* Robert P. Carson, M.D., Middletown Hospital, Middletown;

*Secretary*, L. J. McCormack, M. D., Cleveland Clinic, 2020 East 93rd St., Cleveland 6.

**Section on Pediatrics** — *Chairman*, William E. Baldock, M.D., 4150 Indianola Ave., Columbus 14; *Secretary*, Earl E. Smith, M.D., 13434 Cedar Road, Cleveland Heights 18.

**Section on Physical Medicine** — *Chairman*, Hilda B. Case, M.D., Lakeside Hospital, WRU, 2065 Adelbert Road, Cleveland 6; *Secretary*, William J. O'Rourke, M.D., Veterans Administration Hospital, Cincinnati 20.

**Section on Radiology** — *Chairman*, Herman F. Inderlied, M.D., St. Luke's Hospital, 11311 Shaker Blvd., Cleveland 4; *Secretary*, Ward D. Heinrich, M. D., Huron Road Hospital, Dept. of Radiology, Cleveland 12.

## American College of Physicians Announces Regional Courses

The American College of Physicians has announced a series of courses to be held in various sections of the country during the 1962-1963 season. The full schedule and details may be obtained by writing the college at 4200 Pine Street, Philadelphia 4, Pennsylvania.

Courses in October include the following:

October 1 - 5, "Difficult Contemporary Problems in Internal Medicine," Portland, Oregon.

October 1 - 5, "Basic Mechanism in Internal Medicine," Richmond, Virginia.

October 8 - 12, "Advances in the Medical Aspects of Cancer," New York City.

October 15 - 19, "Biologic Foundations for the Medicine of Tomorrow," Madison, Wisconsin.

October 29 - November 2, "The Rheumatic Diseases — Pathology, Diagnosis and Treatment," Boston, Massachusetts.

A record $245.3 million, eight per cent of sales, was spent on research and development in 1961 by the prescription drug industry, the Pharmaceutical Manufacturers Association reports.

## Physician Population Is Boosted by 4,500

The physician population of the United States and its possessions increased by about 4,500 in 1961, the American Medical Association reports.

A total of 8,023 first licenses to practice medicine and surgery were issued in 1961, the report showed. Since approximately 3,500 physicians died during the year, the physician population increased by about 4,500, compared with a net gain of about 4,330 in 1960.


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In Our Opinion

# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*
*— Justice Robert H. Jackson in AAA Supreme Court Case, 1942*

### AGENCY COMMISSION WANTS HELP OF MEDICAL SOCIETIES

Here's a chance for physicians representing their County Medical Society to take part in a very worthy community project. Hope they don't muff the opportunity.

The Ohio Commission on Aging is setting up a local counterpart in each county. A coordinator is being named to head up the local committee to determine local needs and to promote programs and activities for the senior citizens of the area. An effort will be made to make the local group a representative cross section of the population, to include people of industry, labor, business, government, the professions, private agencies, communications media, etc.

Actually, the objective of both the state and local organizations is to try to put into effect some of the suggestions agreed upon at the 1961 White House Conference on Aging.

The coordinator of each county will be urged to contact the officers of the County Medical Society and invite representation on the county-wide committee.

Obviously, medicine should be represented as medical and health matters are major items in programs of this kind. To repeat: Here's a fine chance for the County Medical Society to render a real service to the public as well as to its own members.

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### IT'S TIME TO PLAY THE OTHER MAN'S GAME

Not long ago one of Ohio's best county seat dailies, commenting editorially on the scrap between the AMA and the Kennedy Administration over H. R. 4222, said:

"Never play another man's game. The adage is sound. Politics is not the doctors' game. They are checked out in the art of healing, not the art of agitating. Politicians can play rings around them when they try to behave like politicians instead of doctors."

We can't help but disagree most heartily with the above sentiment.

Who is going to take the lead in smashing bad health measures if the medical profession takes a seat on the sidelines?

Why shouldn't physicians get into politics? They're citizens like newspaper editors? If some politician decides to make a pending health bill a political football, is that the fault of the medical profession? Who can speak with more authority on medical and health questions than physicians?

Here's hoping that Ohio physicians generally won't follow the poor advice which you have given to them, Mr. Editor.

Here's hoping that Ohio physicians remember that first they are citizens and that citizens had better get into the game of politics if they know what's good for them.

Some politicians are going to run away with the ball unless citizens, including doctors, get off their duffs and enter the game.

Politicians can play rings around their constituents only if said constituents let him do it by default.

In our opinion, Mr. Editor, it's high time for straight-thinking citizens to start playing the other man's game.

---

### HOW HIGH IS UP? A GOOD QUESTION

In our opinion the following excerpts from the president's page of the Los Angeles County Medical Society Bulletin make so much sense that it hardly seems necessary to publish them. However, it's time for the medical profession to face realities. It's time for those few physicians who take the attitude of the public be damned, to realize that they are going to be hurt, and hurt badly, along with the rest of the profession if and when the roof caves in.

Here are the words of wisdom which the L. A. magazine put out:

"All of our fine rhetoric on free enterprise, all of our efforts to sell to business and industry, to labor and the insurance executives the advantages of comprehensive health insurance with deductible and co-

insurance factors will go down the drain if the fees for patients so protected do not bear some realistic proportion to the assured's income.

"We in the medical profession are committed to the importance of good health insurance as our main bulwark against governmental control of the care of the sick. It is important to remember that undue drain on the finances of the insurors, which is to say of the assured, would soon break down the best funded programs. For it is not the insurance company which is bled of 'their' money — in the last analysis it is not the company that suffers; their actuarial experts simply tell them to 'up the premium,' and the public will soon decide a conundrum previously unanswered — how high is up?"

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### CAN'T COAST ON GRAMP'S DEEDS AND REPUTATION

Editorializing on "What's Happened to Professional Prestige?", the *Ohio Bar*, publication of the Ohio Bar Association warns:

"Lawyers can no longer rely on the successes accomplished by their ancestors. This new generation has to prove they themselves are up to the challenges and competition prevalent today. Profession, society, association, forget the name. It's what they comprise that counts."

Ditto so far as physicians and the medical profession are concerned.

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### ETHICAL STATEMENT ON TELEPHONE LISTING

Occasionally physicians are approached by a telephone company to make a listing in the telephone directory of an adjoining county — an area away from the place where the physician resides or maintains his office.

This question was considered several years ago by the Committee on Judicial and Professional Relations of the Ohio State Medical Association. It submitted the following statement of policy to The Council and The Council approved it:

"In our opinion it is unethical and improper for a physician to carry a telephone listing in the telephone directory of an area other than the one in which his bona fide office or offices are located."

It is suggested that physicians make use of and abide by this statement when asked by a telephone directory salesman to do something which would violate professional ethics.

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### SPECULATIVE STORY CAUSES FALSE NOTIONS

A lot of speculation and maybe's published in a medical magazine of national circulation as to whether physicians some day may have to submit to re-examination in order to retain their license to practice has caused some physicians to bristle. As usual, the AMA becomes the whipping boy, getting the blame simply because an AMA official intimated that standards should be set for postgraduate courses and that physicians should participate in continuing education work in order to keep up with new developments in medicine.

Postgraduate courses are being evaluated by the AMA. This is good. Physicians are being urged by the AMA to engage in continuing education of high standard. That's good, also.

The AMA has never seriously considered advocating periodic examinations as a requirement for retaining a license to practice. In fact, it has said that this wouldn't become necessary if postgraduate work is upgraded and physicians take advantage of such courses.

Actually, the AMA couldn't enforce an examination procedure even if it wanted to. Legislation by the states would be necessary. One large national medical society (not the AMA) currently requires members to show evidence of continuing postgraduate work in order to retain membership. If the AMA is considering such, it certainly has been a well-kept secret.


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# New Members . . .

The following are the names of the new members of The Ohio State Medical Association since June 1, 1962. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Clark**

Mary A. Agna, Springfield

**Columbiana**

Stephen Sinclair, East Liverpool

**Cuyahoga**

Hertha Binder, Cleveland
Rudolf E. Binder, Cleveland
Virginia H. Donaldson, Cleveland
George C. Hoffman, Cleveland
Bala Mangru, Macedonia
John L. Stephens, Cleveland
Howard J. Tucker, Cleveland

**Hamilton**

John V. Custer, Cincinnati

HAMILTON *Continued*

James L. Leonard, Cincinnati
Donald J. McSurdy, Cincinnati
Charles H. Rushmore, Ravenwood, West Virginia

**Lake**

Sidney I. Davies, Painesville

**Lucas**

Frederic B. Rothman, Toledo

**Montgomery**

Thomas B. Seitz, Dayton

**Summit**

Nancy Bright Austin, Akron
William A. Cook, Akron
Richard A. Wham, Akron

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Legislation may be required to provide a better definition of a non-profit hospital in Ohio, in contrast to a proprietary hospital, Sidney Lewine, director of Mt. Sinai Hospital, Cleveland, stated in a recent talk at the hospital's annual meeting.

### Program for Rehabilitation Workers Scheduled in Columbus

The second annual meting of the Ohio Rehabilitation Association, September 26 and 27, will bring to Columbus Dr. Claire Ryder, chief of the Long Term Illness Section of the United States Public Health Service, Washington, D. C.

Theme of the state meeting of rehabilitation workers is "Continuity of Rehabilitation Services — a Shared Responsibility." Federal legislation and special workshops will be featured during the two day meeting.

Dr. Ryder will address the meeting at luncheon September 26, and will moderate a luncheon panel of group leaders on September 27. Meetings will be held at Lincoln Lodge, Columbus, and reservations are limited to 225 persons.

Reservations should be sent to Mr. John Gard, Registrar, ORA Meeting, Division of Services for the Blind, 85 So. Washington St., Columbus 15, Ohio.

---

The 74 Blue Shield Plans located in the United States and Canada paid out more than $231,500,000 for care rendered to members during the first quarter of 1962, a record high for a three-month period and almost 91 per cent of the total income of all Blue Shield Plans.


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**increases blood flow to the brain in the "senility syndrome" associated with cerebrovascular insufficiency**



## Surgeons To Meet In N. Y. On September 9 - 13

The International College of Surgeons will hold its 13th Biennial Congress at the Waldorf-Astoria Hotel, New York, N. Y., September 9 - 13. A Mario Dogliotti, M. D., Torino, Italy, President of the College, will preside at the meeting which will attract surgeons from all over the world.

An outstanding and varied scientific program has been arranged by Max Simon, M. D., Poughkeepsie, New York, who is program chairman. Included are postgraduate instructional courses, surgical films, scientific and commercial exhibits, and over 200 papers and panel discussions presented by essayists from 27 different countries.

The Congress is divided into two main program areas: 1. General Assembly Program. 2. Specialty Group Programs. In addition, two special features will be a program for surgical nurses, and the first annual junior candidate surgical seminar.

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**Columbus**—Dr. David H. Greegor recently addressed a luncheon meeting of the Columbus Health Underwriters. Dr. Greegor, chairman of the legislative committee of the Columbus Academy of Medicine, discussed "The King-Anderson Bill — Medicare."—*Columbus Sunday Dispatch.*

## Course in Thoracic Diseases Offered at Ohio State

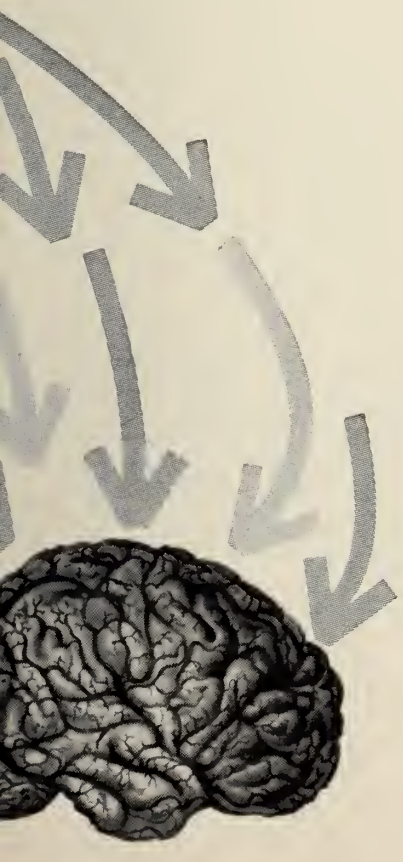
A postgraduate course in Thoracic Diseases, planned especially for the practicing physician, will be presented at the Ohio State University Health Center, Columbus, on Friday and Saturday, September 28-29.

Sponsors of the program are the Ohio State Medical Association, The Ohio State University College of Medicine, Ohio Tuberculosis and Health Association, American Thoracic Society and the Ohio Thoracic Society. The course is approved for nine hours Category I Credit by the Ohio Academy of General Practice.

Registration opens at 8:00 a. m. on Friday, September 28, with the program beginning at 9:00. Program will be concluded before lunch on Saturday. At 2:00 p. m. the football game between Ohio State and North Carolina begins. Football tickets must be reserved by August 29.

Registration will be limited to 150 physicians. Fee (including banquet September 28) is $30.00. Extra banquet tickets are $5.00 each. Wives and guests are welcome.

Applications must be made by September 7. Application should be made to Dr. John A. Prior, Center for Postgraduate Medical Education, 1645 Neil Avenue, Columbus 10.

Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems.[1-3]

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references: 1. Madow, L.: Penn. M. J. 62:861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

NOTE—before prescribing ARLIDIN the physician should be thoroughly familiar with general directions for its use including indications, dosage, precautions and contraindications. Write for complete detailed literature.

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# Activities of County Societies . . .

### BELMONT

The June meeting of the Belmont County Medical Society was a joint program with the Auxiliary at the Belmont Hills Country Club. The featured speaker was Dr. D. Franklin Milan, chairman of the Department of Urology, West Virginia University School of Medicine, whose topic was "Diagnosis and Treatment of Renal Hypertension."

### CHAMPAIGN

Approval of plans for establishing a rheumatic fever registry in Champaign County and induction to membership of Dr. Terry Grogan highlighted a dinner meeting of the Champaign County Medical Society held recently at the Urbana Country Club.

### CLARK

Two medical college professors, Dr. Frank Woolsey, chairman of the department of postgraduate work at Albany Medical College, and Dr. Henry Uhl, his assistant, reported to the members of the Clark County Medical Society and the governing officials of Springfield's Mercy and City Hospitals at a dinner session in the Hotel Shawnee. Their report concerned graduate medical facilities at the two hospitals.

### COLUMBIANA

High blood pressure during pregnancy was discussed by guest speaker, Dr. Keith DeVoe of the Department of Obstetrics at University Hospital, Columbus, during the monthly meeting of the Columbiana County Medical Society.

### FRANKLIN

The Academy of Medicine of Columbus and Franklin County's July program featured the Society's second annual Golf Outing held at the Winding Hollow Country Club. The afternoon of golf, cards, and swimming was followed by a social hour, dinner and a business meeting.

### LAWRENCE

Dr. Ralph Massie, president of the Lawrence County Medical Society, represented the society at a recent luncheon meeting of the Ironton Lions Club. Dr. Massie outlined the provisions of the Kerr-Mills Law and also told of his reasons for opposing the King-Anderson Bill, now before Congress.

### LORAIN

On June 20th a Disaster Alert was held in Lorain County, culminating several months of work by the Lorain County Medical Society Civil Defense Committee which has initiated and carried through the activity of the Lorain County Disaster Organization for the past two years.

The "disaster" was a tornado striking about 1:00 p.m. with 65 casualties who were cared for in the hospitals, thereby testing the efficiency of each hospital's disaster plan.

Following the disaster, members of the Lorain County Medical Society and heads of participating groups (sheriff's dept., civil defense, Red Cross, four hospitals, Boy Scouts, ambulance drivers, and Lorain County Medical Assistants) met for dinner at the Oberlin Inn. After dinner, a critique of the entire program was given by Dr. E. C. Weckesser and his team of observers from Cleveland. Comments were most encouraging and revealed chief improvement needed in speeding the bringing of injured to the

*(Continued on Page 960)*



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## Ohio State Dental Association Names Executive Secretary

For the first time in its history, the Ohio State Dental Association has appointed a full-time executive secretary to head its administrative activities. He is Kenneth W. Meckstroth, former information director of Ohio State University Health Center, and managing editor of the *Health Center Journal.*

Mr. Meckstroth, native of Chicago, has lived most of his life in Ohio. He was reared at New Knoxville, Auglaize County, and was educated at New Knoxville schools and Ohio State University. He was for many years on the reportorial staff of the former *Ohio State Journal,* Columbus newspaper. In 1955, he joined the Washington staff of Senator John W. Bricker, and joined the information service at Ohio State University in 1959.

Service during World War II included assignment as allied task force medical supply officer and depot commander in the Southwest Pacific Theater and the Philippines' Manila Command.

Among other activities he is a founder of the Ohio Children's Society, a voluntary statewide adoption agency, and currently vice-president of its board of trustees. He is a member of Sigma Delta Chi Professional Journalistic Society and the Methodist Church; also a former member of the Ohio Legislative Correspondents Association. The Meckstroth's have one son.

The Ohio State Dental Association has a membership of some 4100 dentists in Ohio. Offices are at 185 E. State St., in Columbus.

Dr. Earl G. Jones, Columbus dentist, for many years was secretary-treasurer of the OSDA, filling the administrative post on a part-time basis. Dr. Jones has been named secretary-treasurer emeritus of the association.

## Reunions Bring Alumni To Ohio State

Reunions of every fifth class of Ohio State University College of Medicine were held before the close of the school year. The first class represented was that of 1912 and the last that of 1957. The 1912 class, celebrating its half-century anniversary, had eight members present.

## Cystic Fibrosis Clinic

A cystic fibrosis referral clinic, held on the fourth Wednesday afternoon of each month, has been started at Children's Hospital, Columbus, under direction of Drs. Thomas K. Oliver, Jr., associate professor of pediatrics at Ohio State, and Gordon Young, instructor.

The Adolescent Clinic, directed by Dr. Francis Eberly, associate professor of pediatrics, is moving into the first floor of Sellers Wing. — *OSU Health Center Journal.*

## County Societies

*(Continued from Page 958)*

aid station and registering there, in order to transport to hospitals.

Approximately 1,000 persons participated in the mock alert, and 45 persons attended the dinner and critique. The exercise was considered a success and most helpful in achieving the goal of improved cooperation and communication, as well as testing the disaster plans of the individual agencies and hospitals.

### MONTGOMERY

Dr. Paul Troup, Dayton, has been elected the 115th president of the Montgomery County Medical Society. Dr. Troup will serve as president-elect during 1963 when Dr. Robert M. Craig assumes the presidency.

Other officers elected are: Dr. Robert Zipf, vice president; Dr. James W. Priest, secretary; Dr. E. E. Archdeacon, treasurer; and Dr. Jerome P. Hochwalt, trustee for a 3-year term.

### SCIOTO

Social Security representatives from Columbus and Portsmouth discussed "Disability Evaluation for OASDI" at the July meeting of the Scioto County Medical Society.

### STARK

A panel discussion by representatives of the Stark County Medical Society was featured at a recent dinner meeting of the Canton Quota Club. Participants were Dr. Maurice Lieber, Dr. William White and Dr. Robert Tschantz.

### TRUMBULL

"The Doctor's Stake in Free Enterprise and the Attitudes of Youth" was the theme of a talk made to the members of the Trumbull County Medical Society and Auxiliary at a recent meeting.

The address was given by William S. P. Cotter of New York City, national organizational director of Young Americans for Freedom.

### TUSCARAWAS

The Tuscarawas County Medical Society was the host at their June meeting to a "thank you" dinner given for the workers of the cancer clinic conducted the past year in Union Hospital.

## Liver Disease Is Subject Of Cincinnati Study

The University of Cincinnati Medical Center has received a grant of $62,717 to cover a three-year liver disease research project, under support of the National Institutes of Health. The project will be headed by Dr. Leon Schiff, professor of medicine and director of the Gastric Laboratory at Cincinnati General Hospital.

# Hospital Cost and Use Study . . .

## Brief of Conclusions Reached by Committee after Extensive Research in Hospitals in Northeast Ohio

THE Citizens Hospital Study Committee of Northeast Ohio was formed in the summer of 1955 for the purpose of examining hospital costs and use. After six years of research, this committee has released its report.

The report, "Hospitals And Their Use in Northeast Ohio, Part I," makes recommendations and draws conclusions based on material assembled from all cases discharged from all hospitals in a five-county area of Northeast Ohio during a three-month period. In all, 63,000 cases were studied and subjected to more than 2,200 statistical analyses. Representatives on the committee were from the public, management, labor, hospitals, the medical profession and Blue Cross. Those representing medicine were Dr. Charles L. Hudson, Dr. John H. Budd, Dr. William J. Engel, and Dr. George L. Sackett. The following major conclusions were drawn:

### Hospital Wage Levels

"The most important single factor influencing the rise of hospital costs during the last 20 years has been rising general wage levels, necessitating corresponding adjustments of hospital payroll. Because hospital services are basically personal in nature and are not generally adaptable to methods of mass production, hospitals have been unable to lessen the effects of rising labor costs by extensive mechanization.

### Utilization of Hospitals

"Improper or unnecessary use of hospitals, to whatever extent it may exist, is not common enough to add significantly either to the cost of hospital care or to Blue Cross subscriber rates.

### Age Distribution

"The key to over-all use of the hospitals is the age distribution of the population served. Analysis of population age groupings offer the most accurate means yet advanced for calculating not only the number of hospital beds needed by the community, but the specific types of beds (medical-surgical, obstetrical, pediatric, geriatric, psychiatric, tuberculosis). Age analysis also can be an important guide to the need for supporting or ancillary services.

### Planning Hospital Facilities

"When a hospital is staffed and ready for patients, the extent to which it is used has comparatively little effect on its operating cost, since more than three-fourths of the cost continues regardless of the number of patients in the hospital and irrespective of the quantity of services they use. Most operating cost results from the continuing pay of the employees who must be available whether or not the flow of patients is great enough to enable efficient use of employee time. One of the greatest potentials for saving therefore rests in careful planning. Each hospital individually and the community as a whole should have

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### Existing Hospital Facilities

"The hospital beds now available or planned in Cuyahoga County are expected to serve the needs of the people until at least 1965. Additional beds should be scheduled for opening only as conditions provide positive evidence that there is need for them, even with the expected expansion of population.

### Variations Among Hospitals

"Differing practices between hospitals often have bearing on operating costs. These differences may affect average occupancy, length of stay, and admissions, use of ancillary services, and many other aspects of hospital operation and use. There are no indications that variations of this nature are the result of improper practices, and there are established safeguards protecting the welfare and safety of hospital patients regardless of such differences. Use of the public's money, whether paid directly, through Blue Cross, or otherwise, also is safeguarded. There is, however, need of further study looking toward the development of new standards which all hospitals and their medical staffs can use to evaluate their own procedures and to judge their operational efficiency.

### Economy of Hospital Operation

"Hospital costs and, correspondingly, Blue Cross subscriber rates will continue to be forced upward by rising industrial and general wage levels. They will rise more rapidly than the prices of manufactured goods because such goods generally require less human labor than does hospital care. There is little opportunity in most hospital departments to mechanize services and control costs through this method. The people should expect these rising costs as part of the price of higher average earnings, a rising standard of living, and a longer life span. Reduction of hospital services and consequent inferior care is the only alternative.

"The hospitals are not exempted from grave concern about rising costs. In their turn, they owe the people the most vigorous efforts to achieve every possible economy. Because they are non-competitive and therefore not subject to the natural controls of the open market, they must develop better methods of demonstrating their financial responsibility through community planning, through the provision of proof that they are using their personnel in an efficient and enlightened manner, and through the adoption of adequate standards for judging the soundness of their expenditures."

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Chillicothe—Dr. Robert E. Swank spoke at a Ladies Night gathering of the B&O Foremen's Club recently. Dr. Swank's topic was health care for the aged.—*Chillicothe Gazette.*

## Crack Down on Micro-Dynameter

Following refusal of the U. S. Supreme Court to review actions of lower courts banning a fake diagnostic machine, Micro-Dynameter, from interstate commerce, the Federal Food and Drug Administration is launching a nation-wide drive to stop the use of the device. The machines will be seized by Federal inspectors.

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## New Nursing Home Rules Adopted

The Ohio Public Health Council has again adopted regulations to govern nursing and rest homes in Ohio, in revised form, following a long court wrangle initiated by dissatisfied home owners. It is anticipated that the new regulations also will be attacked in the courts, possibly delaying the effectiveness of the rules for an indefinite period.

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Cleveland—Dr. Joseph T. Velardo, former director of the department of anatomy at New York Medical College, has been appointed director of the newly created Institute for the Study of Human Reproduction at St. Ann Hospital, Cleveland. This research program in medicine and education has been made possible by a gift of $135,000 from an anonymous donor.—*The Cleveland Press.*


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Obstetrics, General & Surgical, Two Weeks, October 8
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General Practice Review, One Week, October 8
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CLINTON—Foster J. Boyd, Jr., President, 291 N. South St., Wilmington; Emily B. Buchanan, Secretary, 255 Prairie Ave., Wilmington. 1st Tuesday, monthly.

HAMILTON—Edward Woliver, President, 2605 Burnet Ave., Cincinnati 19; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 2. 3rd Tuesday, monthly, September through May.

HIGHLAND—J. Martin Byers, President, 628 Jefferson St., Greenfield; David S. Ayres, Secretary, 1440 N. High St., Hillsboro. 1st Wednesday, every other month.

WARREN—Ray E. Simendinger, President, 21 E. Main St., Lebanon; D. Paul Ward, Secretary, Box 18, Pleasant Plain. 2nd Tuesday, monthly.

### SECOND DISTRICT

CHAMPAIGN—Victor R. Frederick, President, 848 Scioto St., Urbana; Myron J. Towle, Secretary, 848 Scioto St., Urbana. 2nd Wednesday, monthly.

CLARK—George A. Smith, President, 908 N. Fountain Ave., Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, 35 S. Spring St., Springfield. 3rd Monday, monthly.

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GREENE—Alvin B. Salisbury, Jr., President, 11 E. Xenia Drive, Fairborn; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly except July and August.

MIAMI—Dale A. Hudson, President, 221 Orr-Flesh Bldg., Piqua; Jack P. Steinhilber, Secretary, 513 W. High St., Piqua. 1st Tuesday, monthly.

MONTGOMERY—Lynne E. Baker, President, 530 Fidelity Bldg., Dayton 2; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Bldg., Dayton 2. 1st Friday, monthly.

PREBLE—Michael O. Phillips, President, 228 N. Barron St., Eaton; Willard Clark, Jr., Secretary, 228 N. Barron St., Eaton.

SHELBY—Ned A. Smith, President, 739 Spruce Ave., Sidney; William F. Mentges, Secretary, 627 N. West Ave., Sidney. 2nd Tuesday, monthly.

### THIRD DISTRICT

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AUGLAIZE—Robert S. Oyer, President, 310 Perry St., Wapakoneta; Robert S. Sobocinski, Secretary, 7 So. Blackhoof St., Wapakoneta. Called meetings.

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HANCOCK—Benjamin H. Saunders, Jr., President, 1900 S. Main St., Findlay; Thomas W. Darnall, Secretary, 1809 S. Main St., Findlay. 3rd Tuesday, monthly.

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SENECA—Robert R. Schwalenberg, Jr., President, 34 W. Market St., Tiffin; Oswald G. Burkhart, Jr., Secretary, 19 E. Perry St., Tiffin. 3rd Tuesday every month, alternating between Tiffin and Fostoria.

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FULTON—William J. Neal, President, 224 N. Defiance St., Archbold; Robert A. Gerrick, Secretary, 117 Edgewood St., Delta. 2nd Tuesday, quarterly.

HENRY—Raymond J. Manahan, President, 506 N. Perry St., Napoleon; Thomas F. Tabler, Secretary, 332 Railway Ave., Holgate. 1st Tuesday, monthly.

LUCAS—William A. Blank, President, 1838 Parkwood Ave., Toledo 2; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—F. Kraft Ritter, President, 232 E. Second St., Port Clinton; V. William Wagner, Secretary, 122 E. Perry St., Port Clinton. 2nd Thursday, monthly.

PAULDING—Doyt E. Farling, President, Main St., Payne; John H. Schaefer, Secretary, Walnut & Perry Sts., Paulding. Called Meetings.

PUTNAM—Walter W. Donahue, President, 104 B. &. M. Bldg., Leipsic; John R. Brown, Secretary, 135 S. Hickory St., Ottawa.

SANDUSKY—Richard H. Belch, President, 400 Chestnut St., Fremont; Edwin C. Swint, Secretary, 307½ W. State St., Fremont.

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### FIFTH DISTRICT

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CUYAHOGA—Henry A. Crawford, President, 1314 Hanna Bldg., 1422 Euclid Ave., Cleveland 15; Mr. Robert A. Lang, Exec. Secy., 10525 Carnegie Ave., Cleveland 6.

GEAUGA—Kayoshi Masuoka, President, Medical Center, Chardon Plaza, Chardon; Raymond I. Smith, Secretary, P.O. Box 208, Chardon. 2nd Friday, monthly.

LAKE—Maxwell E. Burnham, President, 358 Bank St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor. 2nd Wednesday, monthly, of January, March, May, September and November.

### SIXTH DISTRICT

COLUMBIANA—Harlow F. Banfield, Jr., President, 142 W. 5th St., East Liverpool; Janis Lauva, Secretary, 338 Main St., Wellsville. 3rd Tuesday, monthly.

MAHONING—Charles W. Stertzbach, President, 3610 Market St., Youngstown 7; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 4. Third Tuesday, monthly.

PORTAGE—L. Fred Bissell, President, 12 New Hudson Rd., Aurora; Don P. VanDyke, Secretary, 607 East Main St., Kent. 3rd Tuesday, monthly.

STARK—Graydon D. Underwood, President, Navarre Deposit Bank Bldg., Navarre; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., Canton 2. Second Thursday, monthly.

SUMMIT—Frank M. McDonald, President, 437 Ohio Building "B", Akron 8; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Bldg., Akron 8. 1st Tuesday, monthly.

TRUMBULL—Thomas E. Wilson, President, 438 N. Park Ave., Warren; Mrs. Kay Ticknor, Executive Secretary, P. O. Box 1328, Warren. 3rd Wednesday, monthly.

### SEVENTH DISTRICT

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COSHOCTON—N. Harry Carpenter, President, 713 Main St., Coshocton; Harold W. Lear, Secretary, 133 S. 4th St., Coshocton. 2nd Tuesday, monthly.

HARRISON—James Z. Scott, President, Main St., Box 512, Scio; George E. Henderson, Secretary, Main St., New Athens. Meetings held every three months.

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GUERNSEY—Earl E. Conaway, President, 1198 Clark St., Cambridge; Darell J. Smith, Secretary, Rt. 3, Cambridge Medical Arts Bldg., Cambridge. 1st Thursday, monthly.

LICKING—Lawrence H. Miller, President, 205 S. Prospect St., Granville; James A. Quinn, Jr., Secretary, Newark Hospital, Newark. Last Tuesday, monthly.

## County Societies' Officers and Meeting Dates (Continued)

MORGAN—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta. Called Meetings.

MUSKINGUM—Rankin A. Nebinger, President, Third St., Roseville; Benjamin W. Gilliotte, Secretary, 821 Market St., Zanesville. 1st Tuesday, monthly.

NOBLE—Frederick M. Cox, President, First National Bank Bldg., Caldwell; Edward G. Ditch, Secretary, 415 Main St., Caldwell. 1st Tuesday, monthly.

PERRY—Sydney N. Lord, President, E. Main St., Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—Clarence E. Ash, President, Marietta Memorial Hospital, Marietta; Tuathal P. O'Maille, Secretary, Marietta Memorial Hospital, Marietta. 2nd Wednesday, monthly.

### NINTH DISTRICT

GALLIA—Norman W. Pinschmidt, President, The Gallipolis Clinic, Gallipolis; Thomas P. Price, Jr., Secretary, The Holzer Clinic, Gallipolis. Last Thursday, monthly.

HOCKING—John W. Doering, President, 42 N. Spring St., Logan; Howard M. Boocks, Secretary, Court House, Logan. Called meetings.

JACKSON—John M. Cook, President, Oak Hill Hospital, Oak Hill; Brinton J. Allison, Secretary, Court House, Jackson. Called meetings.

LAWRENCE—Ralph F. Massie, President, 408 Washington St., Ironton; George Newton Spears, Secretary, 2213 South Ninth St., Ironton. Called meetings.

MEIGS—Joseph J. Davis, President, 306 N. 2nd St., Middleport; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy. Called meetings.

PIKE—Robert M. Andre, President, Lake White, Rt. 2, Waverly; Kenneth Wilkinson, Secretary, 330 E. Main St., Waverly. 1st Tuesday, monthly.

SCIOTO—Spencer W. Miller, President, 1021 9th St., Portsmouth; William E. Daehler, Secretary, 1004 24th St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President and Secretary, McArthur.

### TENTH DISTRICT

DELAWARE—Don K. Michel, President, 98 W. William St., Delaware; Edward C. Jenkins, Secretary, 470 S. Sandusky St., Delaware. 3rd Tuesday, monthly.

FAYETTE—Robert A. Heiny, President, 414 E. Court St., Washington, C. H.; James E. Rose, Secretary, 119 E. Market St., Washington C. H.

FRANKLIN—Richard L. Fulton, President, 1211 Dublin Rd., Columbus 12; Mr. William Webb, Jr., Executive Secretary, 79 E. State St., Columbus 15. 3rd Monday, monthly, except May, June, July and August.

KNOX—Delbert C. Schmidt, President, 205 East Chestnut St., Mt. Vernon; Richard L. Smythe, Secretary, Medical Arts Bldg., Mt. Vernon. Usually 1st Wednesday, monthly.

MADISON—Sol Maggied, President, 15 E. Pearl, West Jefferson; Charles Terrill Hay, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—William S. Deffinger, President, Marengo; Joseph P. Ingmire, 28 W. High St., Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Francis W. Anderson, President, 416 E. Main St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Swank, President, 172 E. Main St., Chillicothe; David McKell, Secretary, 60 Central Center, Chillicothe. 1st Thursday, monthly, except June, July and August.

UNION—Walter R. Burt, President, West State St., Milford Center; May B. Zaugg, Secretary, 130 N. Maple St., Marysville.

### ELEVENTH DISTRICT

ASHLAND—Paul J. Sauder, President, 1109 Eastern Ave., Ashland; William H. Rower, Secretary, 1060 Claremont Ave., Medical Arts Bldg., Ashland. 1st Friday, monthly.

ERIE—Carl R. Swanbeck, President, 1218 Cleveland Rd., Sandusky; Donald B. Cuthbertson, Secretary, 421 Wayne St., Sandusky. Alternately, 3rd Tuesday and Thursday, monthly.

HOLMES—Neven P. Stauffer, President, W. Adams St., Millersburg; Luther W. High, Secretary, 109 S. Clay St., Millersburg. 2nd Wednesday, monthly.

HURON—John V. Emery, President, Box 269, Willard; Nino M. Camardese, Secretary, 12 Benedict Ave., Norwalk. 2nd Wednesday, every other month.

LORAIN—Roy E. Hayes, President, Elyria Medical Arts Bldg., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 214 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Nevin J. M. Klotz, President, 162 Main St., Wadsworth; Leroy G. Dalheim, Secretary, 220 East Liberty St., Medina. 3rd Thursday, monthly, except July and August.

RICHLAND—C. Karl Kuehne, President, 480 Glessner Ave., Mansfield; Carroll E. Damron, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—G. G. Stitzinger, President, 1800 Beall Ave., Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday, monthly.

## THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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# ORDER BLANK FOR SIMPLIFIED INSURANCE CLAIM FORMS

Developed by Ohio State Medical Association to Facilitate Furnishing of Information by Physicians to Insurance Companies in Connection With Health and Accident Claims

Mail, with check or cash attached, to:

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# Classified Advertisements

Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

**Physicians seeking locations in Ohio** are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

ATTRACTIVE OFFICE FOR GENERAL PRACTICE with x-ray and dark room. Good hospital near by. Close to Cleveland - Akron - Youngstown. Will rent or sell outright or land lease contract. This community is planning to build a shopping center almost across the street from this office. Box 259, c/o Ohio State Medical Journal.

EXCELLENT OPPORTUNITY for anyone interested in General Practice in pleasant community of 1,000 population (40 miles northwest of Dayton); house-office combination with equipment; no other doctor in town; reasonable price. Available immedaitely. Box 199, c/o Ohio State Medical Journal.

OFFICE SPACE FOR RENT due to death of physician. Established practice for 40 years. Ten miles to Dayton or Middletown hospitals. Community 3000 population. Will rent or lease office completely furnished with all equipment. Patients records also available. Box 236, c/o Ohio State Medical Journal.

COLORED OBSTETRICIAN or PEDIATRICIAN, Cin'ti, Ohio: Excellent opportunity in new medical center; No capital investment required; owner will remodel to suit; wood paneled waiting room, private office, receptionist area and examining rooms. Building also houses Medical Doctor, Medical Laboratory and Dentist Suites. June graduates invited to investigate. Wm. G. Menke, 2532 Indian Mound Ave., Cin'ti 12, Ohio.

PICKER X-RAY - FLUOROSCOPE: Tilt table; 100 MA - 100 KV with all accessories. Michael Truman, M. D., 1070 Millville Ave., Hamilton, Ohio; 895-4541 or 895-9498.

NEW MEDICAL CENTER BUILDING, Superior Location; Liberal Leasing Agreements; Contact Victor Brandel, 3648 Naples Drive, Toledo, Ohio, for information.

GENERAL PRACTITIONER: In Sunbury, Ohio, rapidly growing area 20 minutes from Columbus; good schools, churches, shopping and recreational areas nearby; reasonable taxes and utilities; office in new Sunbury Medical Bldg. available; hot water, heat, air conditioned. Philip Holmes, D. D. S., 1961 graduate of OSU in one side of bldg. Phone Dr. Holmes — Worth. 5-5026, or Ted L. Forman, Worth. 5-5876.

ATTENTION, Residents of Ophthalmology or Otolaryngology: Having been forced to retire because of permanent disability, I am offering for sale: Eye Instruments, Ear, Nose and Throat Instruments, and Rhinoplastic Instruments. Most of the instruments are of stainless or rustless steel and in excellent condition. Box 273, c/o Ohio State Medical Journal.

APPROX. 1500 sq. ft. available for General Practitioner or Internist; long lease available at very nominal rental; ample blacktop parking; north area of Columbus; busily traveled streets; next to modern drug store. Box 271, c/o Ohio State Medical Journal.

EXCELLENT OPPORTUNITY for GENERAL PRACTITIONER: Sell new house and transfer office space; nice community next to Columbus, Ohio. Two open staff hospitals available. Write Box 276, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER — Immediate opening with established medical group in modern, new, fully equipped clinic in a growing suburb of Cincinnati, Ohio. Starting salary open depending on training, and experience, with additional increments thereafter and opportunity for partnership. One other general practitioner in group for scheduling time off, meetings, and vacations. Write full details regarding self, training, and military status to Box 277, c/o Ohio State Medical Journal.

WANTED: Young American born G. P. as associate, in prosperous rural community, Akron-Cleveland area. No investment needed, guarantee plus, modern offices. Modern hospital facilities. Box 279, c/o Ohio State Medical Journal.

WELL ESTABLISHED General and Industrial Practice with two man partnership in east suburb, Cleveland, Ohio; need third man. Salary, subsequent partnership. Box 280, c/o Ohio State Medical Journal.

## OPPORTUNITY

This community is looking for two general practitioners to locate in a newly remodeled, spacious and completely modern clinic. The city has a population of 1,800, and is located in one of the richest agricultural areas in Wisconsin. The city also has two sound and growing industries with a combined payroll of about 700, which in itself can virtually keep the two men busy.

This is an excellent opportunity for doctors who have completed their internship or for established physicians seeking to relocate. The living conditions, working conditions and income potential are ideal. Housing is available. Write or call the Chamber of Commerce, Brillion, Wisconsin.

AVAILABLE. General practice in Cosmopolitian suburb near Columbus, Ohio, includes air-conditioned office complete with ECG, BMR, X-ray, etc.; amazingly low investment required. Excellent opportunity for young physician seeking to establish in a highly desirable, rapidly expanding residential area. Present physician relocating out-of-state, but will make necessary introductions, to insure incoming physician of proper beginning. For complete information, contact Box 282, c/o Ohio State Medical Journal.

WANTED: GENERAL PRACTITIONER willing to assist in large practice in Western Hills of Cincinnati. Excellent opportunity for the ambitious neophyte willing to start in percentage partnership after short preliminary trial. Adequate salary. Write or phone, Elliott A. Hilsinger, M. D., 3180 Harrison Ave., Cincinnati 11, Ohio; 661-1500.

FOR RENT: Office suite in new building, air-conditioned, on ground floor; ample parking. Located near hospital in community needing additional doctors. Reply Box 253, c/o Ohio State Medical Journal.

OFFICE SUITE Recently occupied by physician near downtown Piqua, available Sept. 1; approx. 1000 sq. ft.; in fine condition; population 20,000 plus large surrounding area; two hospitals. Apply J. R. Bateman, 407 W. High St., Piqua; Phone 773-0508.

WANTED: Full-time physician for Emergency Room. Salary commensurate with qualifications. Apply: Alfred C. Buergler, M. D., Chairman, Emergency Room Committee, St. Thomas Hospital, 444 N. Main St., Akron 10, Ohio.

SOUTHERN MICHIGAN GENERAL PRACTICE FOR SALE: Spacious, comfortable combination office and residence in a small city with fine modern hospital. Buyer pays for building, office furniture and equipment only. All records and accounts receivable are included. Practice will be active until September first, when the doctor will leave to accept a position in an educational institution. Box 284, c/o Ohio State Medical Journal.

EXCELLENT COLUMBUS OPPORTUNITY: Location at 2675 W. Broad St., at present occupied by internist for 7 years; previously by general practitioner for 30 years; all private offices, private consultation room, business office, x-ray and three treatment rooms, plus large reception room. Excellent corner location. BR. 6-3305; after 6 p. m., BR 9-5650.

MY NEW FIRST FLOOR OFFICE 1200 square feet for rent or sale since I recently entered public health full time. My practice, including general surgery, available to tenant. Natural stone front, knotty pine and painted interior. Acoustic ceilings, air conditioned, well insulated and quiet, wired for radio and intercom. Beautifully carpeted and arranged for two doctors. Two doors from drug store, equidistant from our three hospitals. Close to turnpike entrance and exit. Adequate private parking. John M. Van Dyke, M. D., 836 Auburn Pl., N. W., Canton, Ohio.

FOR SALE: 100 MA X-RAY, North American Phillips with spot film attachment. 6 yrs. old, in excellent condition. Will sacrifice for quick sale. Box 288, c/o Ohio State Medical Journal.

PRACTICE FOR SALE: Southeastern Ohio, suburban area, nice growing community of 5000 people with good hospital facilities. Box 286, c/o Ohio State Medical Journal.

*(More Classified Ads on Facing Page)*

## Classified Advertisements (Contd.)

L-F DIATHERMY and L-F BASALMETER for sale. Both in excellent condition. Best reasonable offer accepted. Charles E. Casto, M. D., 1630 Schiller Avenue, Cuyahoga Falls, Ohio; Phone WA 8-3026.

OB-GYN man, Residency trained — 3 years. Board eligible; Seeking Association or an area where services are needed. Available March 1963. Box 287, c/o Ohio State Medical Journal.

FOR SALE: Medical equipment of general practitioner and established location (100 years) Western Cincinnati available. Services of registered nurse assistant may be continued. Call 621-1045, Cincinnati, Ohio, or write to Steer, Strauss & Adair, Attorneys at Law, 2215 Union Central Building, Cincinnati 2, Ohio.

## Columbus Academy Produces Medical TV Series

"The Physicians," a series of 11 television medical programs, under the sponsorship of the Columbus Academy of Medicine Educational Foundation, recently began a summer run over WBNS-TV, Columbus. The show, being aired from 6:30 to 7:00 P. M., E.S.T., through August 28, has received enthusiastic support from WBNS viewers.

Drs. L. Chandler Roettig, chairman of the Television Committee of the Columbus Academy, and John N. Meagher, co-chairman, are cooperating with Mr. Gene McPherson of WBNS-TV in the production of the series.

Eleven topics have been chosen for presentation, each to be the responsibility of a physician serving as a co-chairman who has a particular interest in the subject matter. The first presentation on June 19 was "Biography of a Doctor" under the direction of Dr. Robert F. Daly. On June 26, "Socialized Medicine" was the topic under the direction of Dr. Willard B. Andrus. Following these were the following: July 3, "Killers on Wheels" under the direction of Dr. Wesley Furste; July 10, "Quackery in Medicine," Dr. Dana Cox; July 17, "Two Faces of Radiation," Dr. Dana Schmidt and Dr. George Callendine; July 24, "The Machinery of Medicine," Dr. Thomas J. Williams; July 31, "Medical Research," Dr. Albert W. van Fossen.

Completing the series, are the following: August 7, "The Cost of Medical Care," under the direction of Dr. Warren W. Smith; August 14, "Diseases of Civilization," Dr. Robert B. Stevenson; August 21, "The Search for a Typhoid Carrier," Drs. Thomas B. Williard and Ollie Goodloe; and on August 28, "Doctor of the Day," Dr. Joseph H. Shepard.

Video tapes of each of the programs are being made and will be made available to other County Medical Societies, on request, following the completion of the series.

On July 9, the Columbus Academy sponsored "Emergency," a one-half hour TV program about socialized medicine, over WLW-C. The cost of this program was defrayed by donations from Academy members.





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posed upon a regularly accented accompaniment.
rag'weed (-wēd'), n. a Eng. The ragwort b U. S.
Any of several coarse herbs (genus Ambrosia) typi-
fying a family (Ambrosiaceae, the ragweed family)
having heads of flowers subtended by an involucre
of bracts; esp. a very common weed (A. elatior)
with deeply lobed or dissected leaves; and the great,
or giant, ragweed (A. trifida), with trilobate leaves
The cockleburs (see COCKLEBUR) also belong to this
family.
rag'wort, (-wûrt'), n. Any of several plants (genus
Senecio) of the aster family, as the golden ragwort
(S. aureus) of the United States, having an open
corymb of yellow-rayed flowers.
ra'ia, ra'yah (rä'yä), n. [E., fr. Turk. ra'aya, fr. Ar.
ra'aya, coll. sing. ra'iyah, flock, herd.] A non-Mos-
lem subject of
raid (rād), n. [
1. A hostile
an inroad
sudden or
Ottoman Empire.
road. See ROAD raid, way.]
ursion; a foray; orig.,
men; hence, a




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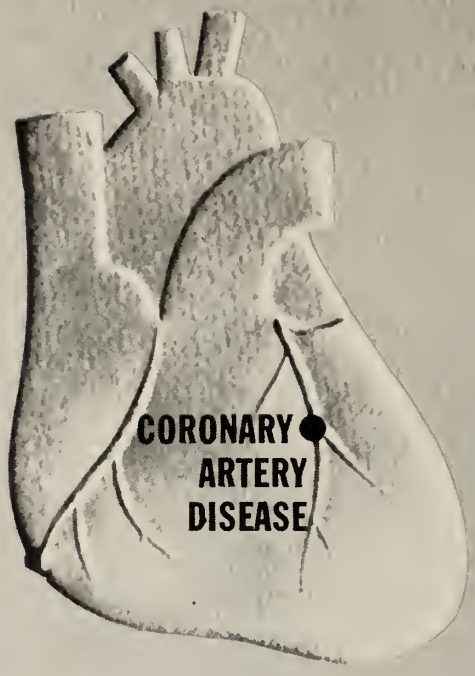
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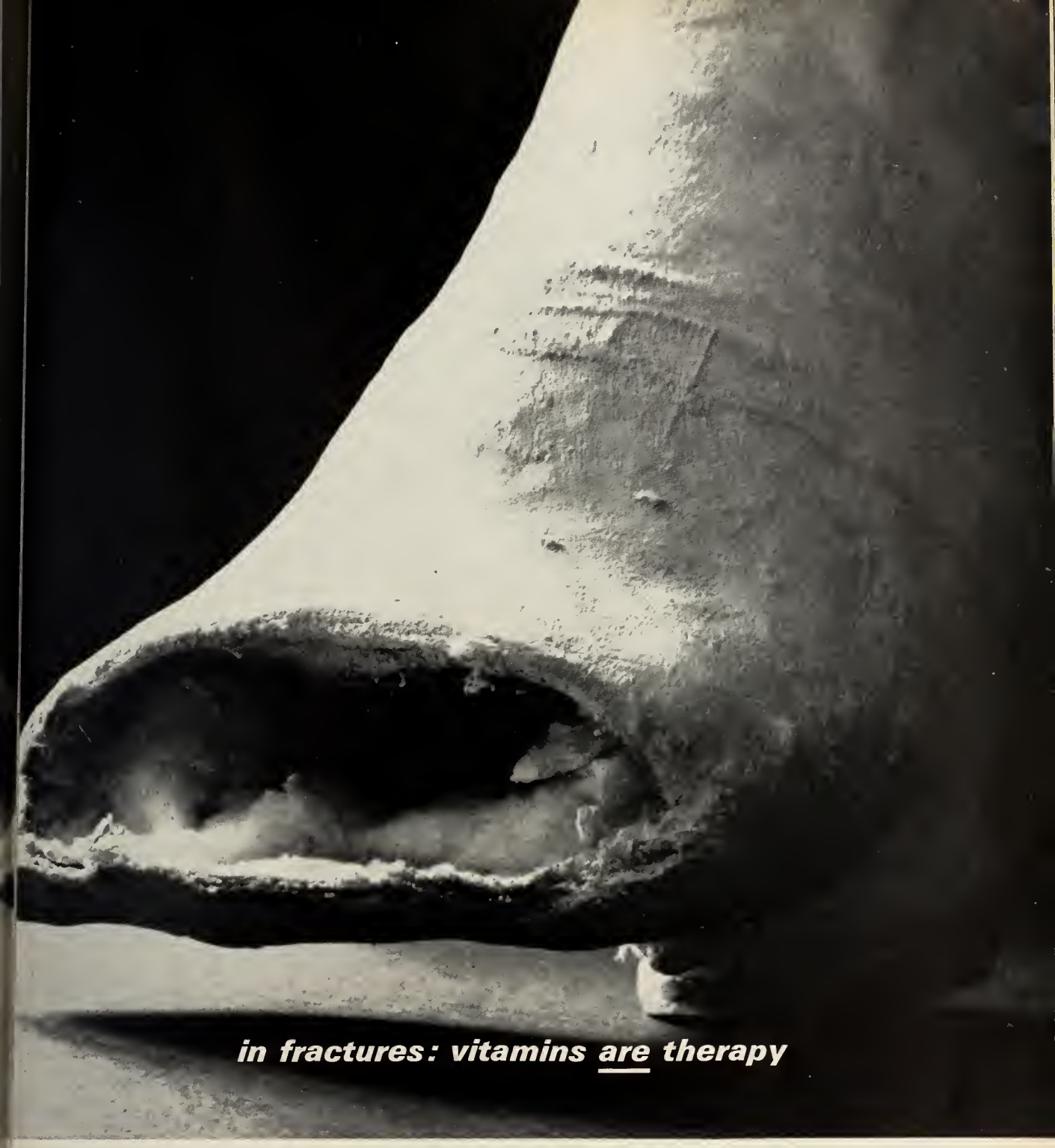
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*References:* (1) Root, H. F., and Bradley, R. F., in Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 10, Philadelphia, Lea & Febiger, 1959, pp. 411, 437. (2) Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: *ibid.,* pp. 188-189. (3) Marks, H. H., *et al.:* Diabetes 9:500, 1960. (4) Marble, A., in Summary of Conference on Diabetic Retinopathy, Survey Ophth. (Part 2) 6:611-612, 1961.

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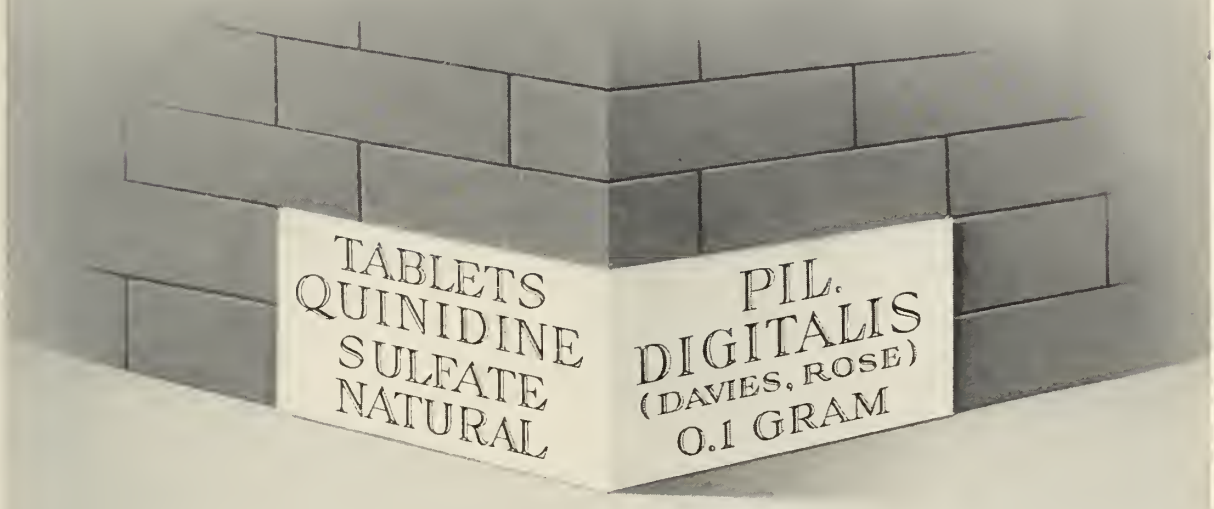
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| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
| Toledo | Toledo Health Department<br>635 N. Erie St. | CH 4-1961—(Day)<br>EV 5-4661—(Night) |
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Part I deals with the pathogenesis, functional diagnosis, treatment, and prophylaxis of diseases of the digestive organs. A well documented paper on the treatment of peptic ulcer by intraperitoneal novocain presents interesting findings. The possible common etiology of peptic ulcer and chronic gastritis is discussed in an article on the effect of Sympathol on the gastric and hepato-pancreatico-duodenal secretion in both healthy persons and in patients with chronic gastritis. Another paper of considerable interest to Western scientists deals with the influence of individual dietetic dishes on the conditioned reflex secretion of the gastric glands in patients suffering from peptic ulcer and chronic gastritis.

Part II covers the pathogenesis, functional diagnosis, treatment, and prophylaxis of diseases of the cardiovascular system. Among the topics treated are the effects of physical exercise on hypertension, atherosclerosis of the pulmonary artery and its branches, and the compensatory power of the myocardium in hypertension.

**The Achievement of Soviet Medicine,** by L. Fridland, M. D. ($6.50, *Twayne Publishers, New York 3, New York.)*

**Soviet Medical Research Related to Human Stress,** by William H. Fitzpatrick, Ph. D., and Chester W. DeLong, Ph. D. (40¢, Public Health Service Publication No. 853, *Superintendent of Documents, U. S. Printing Office, Washington 25, D. C.)*

**Drugs of Choice 1962-1963,** by Walter Modell, M. D., and contributors. ($14.50, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

**Therapeutic Exercise:** Volume III of **Physical Medicine Library,** by Sidney Licht, M. D. ($16.00, Second edition, *Elizabeth Licht Publisher, 360 Fountain Street, New Haven, Conn.)*

**Biochemical Values in Clinical Medicine,** by Robert D. Eastham, M. D. ($3.75, *Williams & Wilkins Company, Baltimore 2, Md.,* exclusive U. S. Agents.)

**Essential Hypertension:** An International Symposium at Herrenchiemsee, June 17th - 20th, 1959, sponsored by Ciba. Edited by E. Buchborn of Munich and K. D. Bock of Basle. *(Springer-Verlag, Heidelberg, West Germany.)*

**The Closed Treatment of Common Fractures,** by John Charnley. ($10.00, Third edition, *The Williams & Wilkins Company, Baltimore 2, Md.,* exclusive U. S. Agents.)

**Functional Neuro-Anatomy,** by A. R. Buchanan, M. D. ($8.50, Fourth edition, *Lea & Febiger, Philadelphia 6, Pa.)*

**Heredity In Ophthalmology,** by Jules Francois, M. D. ($23.00, *The C. V. Mosby Company, St. Louis 3, Mo.)*

**Pharmacological Principles of Medical Practice,** by John C. Krantz, Jr., and C. Jelleff Carr. ($15.00, Fifth edition, *The Williams & Wilkins Company, Baltimore 2, Maryland.)*

**The Adolescent Society,** by James S. Coleman. ($6.95, *The Free Press of Glencoe, Inc., A Division of the Crowell-Collier Publishing Co., New York 11, New York.)*

**Anesthesia Abstracts: Volume 55,** by John S. Lundy and Florence A. McQuillen. ($4.00, *Burgess Publishing Company, Minneapolis 15, Minn.)*

**China Doctor,** by Raymond S. Moore. ($3.95, *Harper & Brothers, New York 16, N. Y.)*

**Nursing Home Administration,** by John D. Gerletti, C. C. Crawford and Donovan J. Perkins. ($6.50, *Attending Staff Association, 7601 E. Imperial Highway, 400 Building, Room 129, Downey, California.)*

**Abdominal Operations,** by Rodney Maingot, F.R.C.S., London, with special articles by 36 British and American contributors. ($29.50, Fourth edition, *Appleton-Century-Crofts, Inc., New York 1, N. Y.)*

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Simon, F. & Bernstein, A.: "The Treotment of Obesity in Potients with Cardiovoscular Disease," Angiology, 32-37, Jan. 1961.

Plotz, M.: Modern Monogement of Obesity, J.A.M.A., 170:1513-1515 (July 25) 1959.

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1. Ford, R. A., and Blanchard, K: Journal-Lancet 78:185, 1958

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Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

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Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New
GRIP-TIGHT CAP
for Children's
Greater Protection



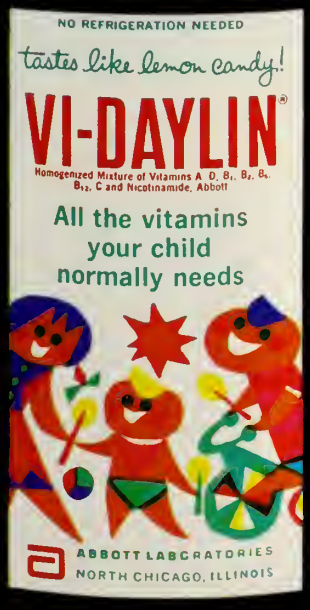

THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.



# How do the lemons get in the Vi-Daylin?

Perhaps this should be cleared up once and for all. There are *no* lemons in Vi-Daylin. If you've ever tasted Vi-Daylin, this might surprise you. Certainly, it would surprise the youngsters. To most of them, Vi-Daylin is liquid lemon candy, and that's *that*. But if it's deception, it's sensible deception. You never have to badger the kids into taking their vitamins. Nice to know, too, that this matchless matching of candy essence and color elegance can be found in all the forms and formulas of Vi-Daylin.

VI-DAYLIN—Vitamins A, D, $B_1$, $B_2$, $B_6$, $B_{12}$, C, and Nicotinamide, Abbott; VIDAYLIN-M—Homogenized Mixture of Vitamins with Minerals, Abbott; VI-DAYLIN-T—High Potency Multivitamins, Abbott.




Remember, there are *three* liquid formulas: Vi-Daylin, ViDaylin-M® (with minerals), and ViDaylin-T® (therapeutic). And if patients get a little owlly and won't touch *anything* in a spoon, you can give them the new Chewable (please see back of this page).

Each delicious, 5-cc. teaspoonful of Vi-Daylin supplies the following proportions of the Minimum Daily Requirements of:

| | | MDR (Children) | MDR (Infants) |
|---|---|---|---|
| Vitamin A | 0.9 mg. (3000 units) | 1 | 2 |
| Vitamin D | 10 mcg. (400 units) | 1 | 1 |
| Thiamine HCl ($B_1$) | 1.5 mg. | 2 | 6 |
| Riboflavin ($B_2$) | 1.2 mg. | 1⅓ | 2 |
| Ascorbic Acid (C) | 50 mg. | 2½ | 5 |
| Nicotinamide | 10 mg. | 1⅓ | 2 |

Also supplies cyanocobalamin ($B_{12}$) 3 mcg. and pyridoxine Hydrochloride 1 mg.

209035A

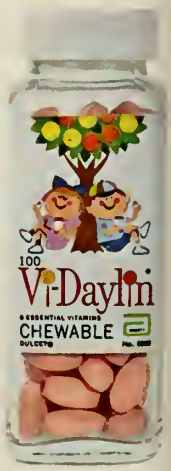
Abbott Laboratories
North Chicago, Illinois

Gentlemen,

My family enjoys your chewable vitimans. It seems like we can not get enough of your vitimans. My sister enjoys your vitimans so much that she ask for more but cannot have no more. I like them because my mother does not have to worry about scolding us when taking it. Its good because you don't have no worries about something falling on the floor. If you kept on making these vitimans all the worlds children would be happy again. Now I would like to know whether I may have any information on the Middle West. You see my class and I are studying it. So if the information can be given I thank you very much.


# "...all the worlds children would be happy again."

(an unsolicited testimonial from an actual letter)




ABBOTT

*If you have patients on a cholesterol depressant diet, this will be welcome news:*

General Mills is now making available, through grocery stores, a Safflower Oil which is totally acceptable in the diet, and which is priced reasonably.

# SAFF·O·LIFE
## Safflower Oil




As you know, Safflower Oil is higher in poly-unsaturates and lower in saturated fats than any other type of readily available vegetable oil.

When an increased poly-unsaturated fatty acid intake is desirable, you can recommend Saff-o-life Safflower Oil. You can do so with the assurance that the patient will find it completely appetizing—clear, light and fresh-smelling—and priced at a level which poses no problem.

**Ratio of Linoleates* to Saturates**
*(Poly-Unsaturates)

SAFFLOWER OIL • 9.0 to 1.0
CORN OIL • 5.3 to 1.0
SOYBEAN OIL • 3.5 to 1.0
COTTONSEED OIL • 2.0 to 1.0
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Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to General Mills, Inc. Address your inquiries to Professional Services Director, General Mills, Inc. Dept. 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.



# Put your low-back patient back on the payroll

*Soma relieves stiffness —stops pain, too*

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET Q.I.D.

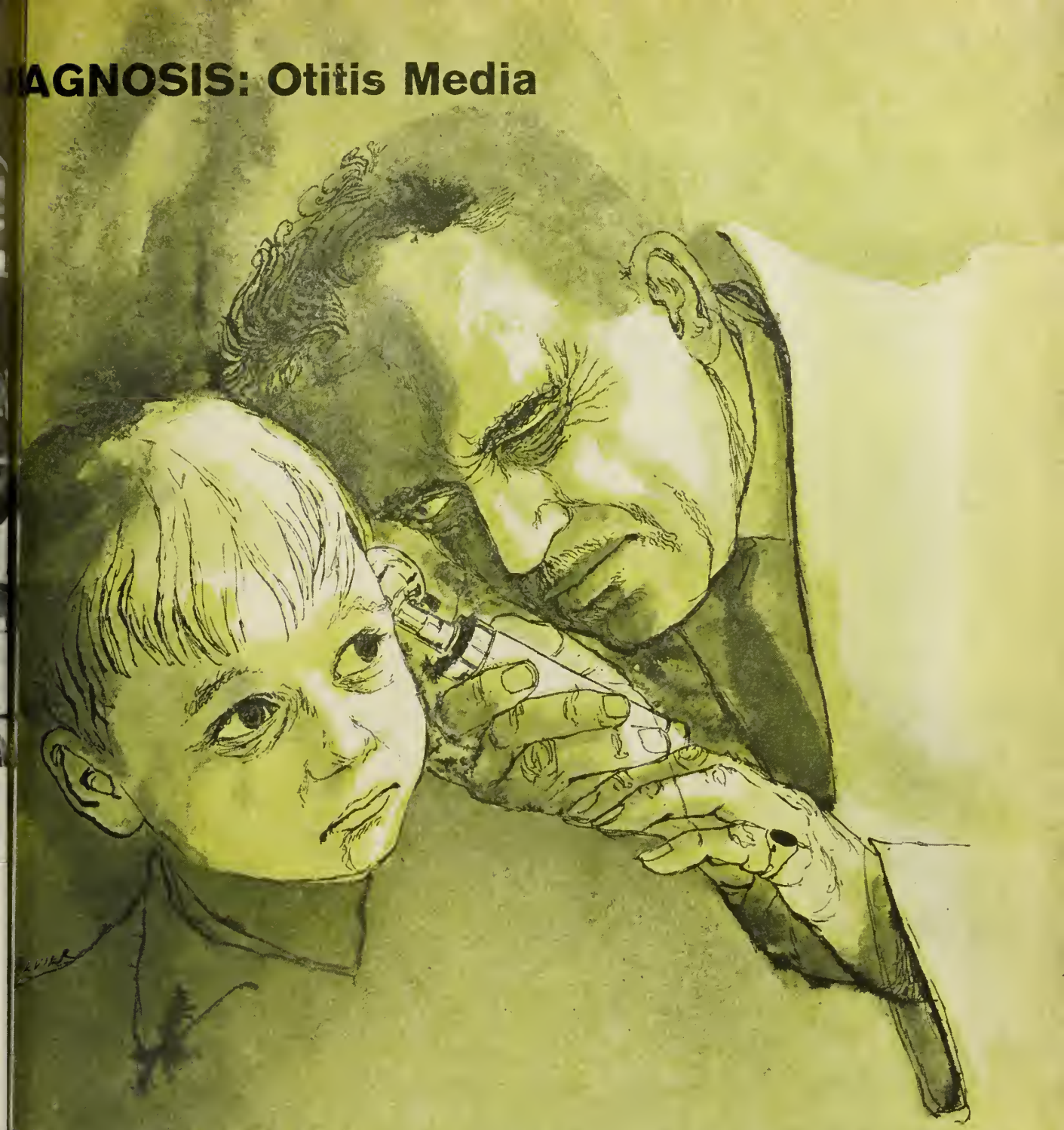
*The muscle relaxant with an independent pain-relieving action*

# SOMA®

*(carisoprodol, Wallace)*

Wallace Laboratories, Cranbury, New Jersey

**AGNOSIS: Otitis Media**



**HERAPEUTIC NEED: Suppression of the causative organ-ms and symptomatic relief.**

**NTIBIOTIC: DECLOMYCIN®**

Demethylchlortetracycline Lederle

**ecause of its higher antibacterial activity, and its effective-ess against a wide spectrum of bacteria.**

uest complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

DERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



# Day and night– less wheezing, coughing, labored respiration in chronic bronchitis and emphysema

New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

| | |
|---|---|
| Isuprel® (brand of isoproterenol) HCl | 2.5 mg. |
| Ephedrine sulfate | 12 mg. |
| Theophylline | 45 mg. |
| Potassium iodide | 150 mg. |
| Luminal® (brand of phenobarbital) | 6 mg. |
| Alcohol | 19% |

*Adult Dose:* 2 tablespoons 3 or 4 times daily.

*How Supplied:* Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

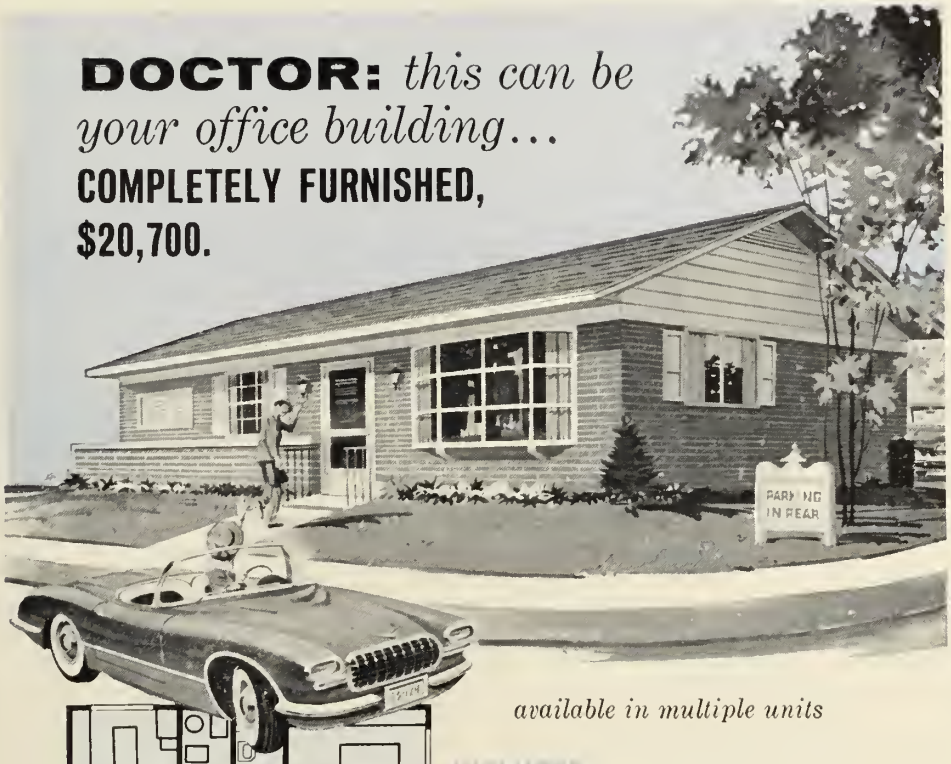
Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

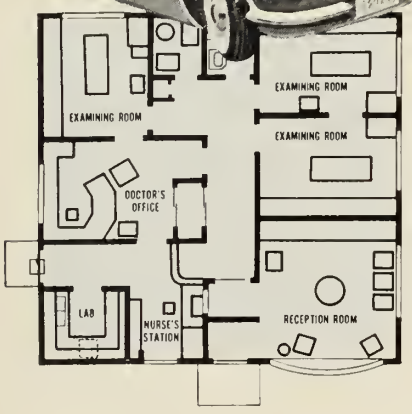
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New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.

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**COMPLETELY FURNISHED, $20,700.**




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*...just unlock the door and you're ready to see your first patient!*

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*Gentlemen: I am interested!*

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*Logical prophylactic measure*

*for your vaginitis patients*

# Tassette®

INTERNAL MENSTRUAL CUP

*eliminates bridge*

*for possible*

*cross-contamination*

TASSETTE eliminates the bridge for possible cross-contamination during menstruation. No pad. No string. No contact between anal area and vulvovaginal canal.

TASSETTE offers outstanding advantages over semi-internal and external methods. Safe. Effective. Odorless. A new dimension in comfort and hygienic protection never before available.

*Write for professional sample and literature on your letterhead.*

ANATOMICALLY CORRECT



Small, soft rubber cup nests securely in vagina.

ALLOWS FREE FLOW from uterus. Does not block or obstruct cervix.

Tassette Inc. ■ 170 Atlantic Square ■ Stamford, Conn.

*Ref:* Pena, E.F., Obst. & Gynec., *19*:794, 1962. Karnaky, K.J., Obst. & Gynec., *19*:688, 1962. Pena, E.F., Obst. & Gynec., *19*:684, 1962. Karnaky, K.J., Tri-State M.J. Sept., 1961. Burrus, S. Jr., Am. J. Obst. & Gynec. *80*:390, 1960. Karnaky, K.J., Tri-State M.J. Aug. 1960. Karnaky, K.J., Tri-State M.J., June, 1960. Liswood, R., Cur. Med. Dig., *26*:92, 1959. Schaefer, G., Clin. Obst. & Gynec., *2*:535, 1959. Liswood, R., Obst. & Gynec., *13*:539, 1959. Dickinson, R.L., JAMA, *128*:490 (June 16) 1945. Biskind, Mod. Med., *22*:128 (June 15) 1954.

**Stelazine® will stop anxiety—but not your patient!**
brand of trifluoperazine

To be truly useful in your office patients, an ataractic agent must not only relieve anxiety; it must also leave these patients sufficiently alert to engage in their normal activities.

'Stelazine' is such an agent. Its ability to relieve anxiety without producing appreciable sedation has been established in thousands of patients and documented by many published reports. Typical is the finding of Kolodny,[1] who concluded that the primary advantage of 'Stelazine' over many other tranquilizers seems to be "its ability to relieve symptoms of anxiety without undue interference with alertness."

When you wish to relieve anxiety, yet encourage the patient to engage in his normal activities, consider 'Stelazine'.

1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

For prescribing information, please see *PDR* or available literature.

*Smith Kline & French Laboratories, Philadelphia*
*leaders in psychopharmaceutical research*

SK&F



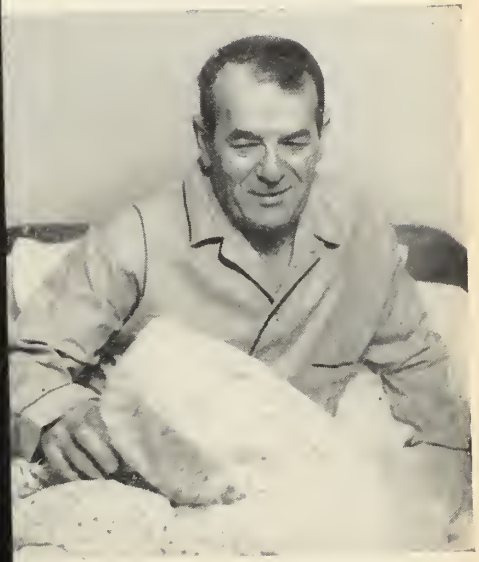


Thanks to 135 tiny "doses" throughout th

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# ight, the arthritic wakes up comfortable



Morning stiffness may be reduced or even eliminated as a result of therapy with the only steroid in long-acting form. And the slow, steady release of steroid makes it possible in some cases to reduce the frequency of administration and/or the total daily steroid dosage.

## Medrol* Medules*

Each hard-filled capsule contains Medrol (methylprednisolone) 4 mg. Also available in 2 mg. soft elastic capsules.

Supplied in bottles of 30 and 100.

Upjohn

The Upjohn Company, Kalamazoo, Michigan

Reminder advertisement.
Please see package insert for detailed product information.

The Historian's Notebook

# History of the Lakeside Unit Of World War I

HARRY D. PIERCY, M. D.*

## Part V

*(Continued from August Issue)*

THE home of Emile Blondel was another lavish and beautiful place. He was president of the "French Homes Association" and, I believe, he was in the steel business. He and Colonel Bunts became great friends, a friendship that continued years after the war and was taken up by his son, Dr. Alex Bunts, after the death of Col. Bunts in 1928. The officers and nurses were frequently invited to this home and we were encouraged to cultivate a cordial and easy relationship. One could continue on this subject for a long time but it would grow dull. I can merely mention the Bourels, the Paillets, the Langs and others who with effort and personal sacrifice entertained us and made our prolonged absence from home more tolerable.

I have recounted the many social affairs given by the members of the "French Homes Association" to which were invited the nurses and the officers. I have left the impression that the Association was interested in entertaining only the commissioned ranks. Such was not the case. The enlisted men also were invited to the "French Homes." It is well known that military etiquette forbids the social mingling of commissioned and noncommissioned ranks and the ease and grace of these functions depended upon the observance of this rule. The account here given was taken from my personal diary and I could write only about affairs in which I was concerned.

### The Unit Entertains the "French Homes Association"

As our social obligations mounted, the officers and nurses made plans to entertain the "French Homes Association." Invitations were sent out. The beds and the bedside tables were cleared from Huts 13 and 14. These were thoroughly cleaned and the bare walls and rafters were made gay with bunting and flags, and with ivy, evergreens and mistletoe. The Huts looked wonderful! The party was scheduled for January 9. On the afternoon of the 8th, M. and Mme. Burel and Colonel and Mme. Ferrere came to call at the hospital. They were officers of the French Homes Association. We had tea and some music and then made the rounds of the camp. It seemed they wanted to get the lay of the land for the party the following day. They departed looking pleased and revealed an air of great expectations.

On the afternoon of January 9 the French came in droves; it was estimated there was a total of 300. Most of them assembled in Hut 14 which was set with chairs and tables and they were served coffee, cakes, doughnuts and ice cream. The doughnut was a great success, hundreds were consumed. During this hour of social formalities, a short musical program was given and then our Jazz Band in Hut 13 started off with a one-step. The crowd rose in a body and made for the dance hall. Everybody, old and young, wanted to learn the American dances; we had our hands full and our feet stepped on, but we disappointed nobody.

The thing much appreciated was the wonderful punch Mess-Sergeant Enger made. Never before or since have I tasted such a delightful punch. It was inviting, and it had a slow fuse; it gave no warning. The French partook of it as though it were champagne. The party became gay, delightful and most amiable and the dance kept on until the Jazz Band stopped at 6 p. m. Someone continued on the piano for another 15 minutes and then we gave a pause, that some might get the idea to start for home. There was a slow departure. We ended by having eight of our guests come to our mess hall for dinner.

Mme. Pellerin, who stayed for dinner, invited Colonel Bunts to bring seven of his officers to her home for dinner on January 18. Our Ford car made two trips to get us there. We were given a cordial reception. After a glass of dry Madeira we went in to dinner. We were served a banquet of seven courses. After the coffee, liquors and cigars, and the postprandial conversation, Colonel Bunts started off with his group in the Ford, when M. Pellerin

*Dr. Piercy, Cleveland, is a member of the courtesy staffs of University Hospitals, and St. Luke's Hospital, Cleveland, Ohio.
Submitted June 23, 1961.

# Relieves Anxiety and Anxious Depression



The outstanding effectiveness and safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom — has been clinically authenticated time and again during the past six years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

## Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms, liver damage or agranulocytosis
3. Does not muddle the mind or affect normal behavior

**Miltown®**
meprobamate (Wallace)

***Usual dosage:*** One or two 400 mg. tablets t.i.d.
***Supplied:*** 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® — 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

CM 6709

WALLACE LABORATORIES / *Cranbury, N. J.*

called out not to send back the car, for he would send the others in his limousine. This he did and our party of four arrived on the heels of the first departed. This courtesy did not diminish the warm and understanding feeling we had for our French friends.

### Christmas 1918

The Christmas season 1918 was a busy time both professionally and socially. It was the first postwar Christmas and the whole hospital base made much of it, feeling the pressures of the preceding years removed, and cheered by the confidence in an early return home. Our wards were not filled with battle casualties but we had a large number of the starving, vermin-infested, unbathed British who had spent up to three years in German prison camps. After the Armistice, the gates were thrown open and the prisoners were waved to the west. Many were met staggering on the way, picked up by ambulance and carried to the hospital. They had to be cleaned up and carefully fed. Many came down with bronchitis and pneumonia. Flu was rampant and many died. The worst of this was over as December weeks went by and Christmas approached.

The nurses and orderlies were busy decorating the wards with greens, holly, mistletoe and Christmas hangings. They were happy and busy as bees making pies, candy and fancy decorated cakes, fashioning wreaths and cutting colored paper. Except for the weather, which was warm, wet and rainy, Christmas was in the air! On Christmas Eve at 10:00 p. m. the Christmas Carols started; carrying candles and singing, rounds were made on all the wards. There were many moist eyes among the patients and choralers. On one ward a British Sergeant-Major rose to speak for his bed-mates. He said "Me lads and I have had many Christmas Eves but none more pleasant than this."

### Midnight Mass

After this a truck load of us went down to Midnight Mass at the Cathedral. We arrived at the edge of a veritable rabble before the doors. It was a motley crowd, soldiers of all nations and all ranks, French of all social classes fused into one struggling mass, crowding, pushing and elbowing. After a half hour's struggle I somehow got within and free of the crowd, and before me, far away shone the altar lights and between them and me, the kneeling multitude. The great organ filled the air with pealing tones and then a distant priest intoned the Mass and the muttered responses rose from a thousand throats. It was an impressive and solemn experience and I felt fortunate to be there.

The week of Christmas to New Year's Day was filled with social events. All the hospitals held open house; there were teas and dances, and small groups of officers with cigarets and Johnny Walker served with warm bottled Prima Water. During this week we gave a dance for our nurses which was a gay and happy affair and we threw another dance on New Year's Eve. During this time our Hospital was being cleaned out. There were no more "convoys in." On January 22 orders were received to close the hospital. Our wards were cleared out the following day and the remaining patients were sent to neighboring British hospitals.

On the 23rd our flags were hauled down for the last time. "Retreat" was sounded and the detachment formed ranks before the Administration Building. The color guard formed in front of the flagpole and as "the colors" was sounded on the bugle the three flags on the halyard, the British flag, the Red Cross flag and the "Stars and Stripes" slowly floated down on the breeze. The flags were cut from the halyard, carefully folded and borne away by the color guard. The detachment did fours right and followed. It was an impressive moment.

The flagpole was dug up the same day, put on a truck and hauled to the dock. It was addressed to General Crile. It remained in his cellar on Derbyshire Road in Cleveland for some years. When the new University Hospitals were constructed this flagpole was erected in front of Lakeside Hospital in 1932. It was dressed as it was in France except that our "Union Jack" replaced the British flag. With the passage of years, worms and slow dry rot wrecked the flagpole and about five years ago it had to be removed. Myer G. Wenning, a member of the Unit secured some of this wood and made three small replicas equipped with halyards and flags and presented one to the Nurses' organization, one to the Officers and one to the Enlisted Men. These are brought out as these organizations meet from year to year.

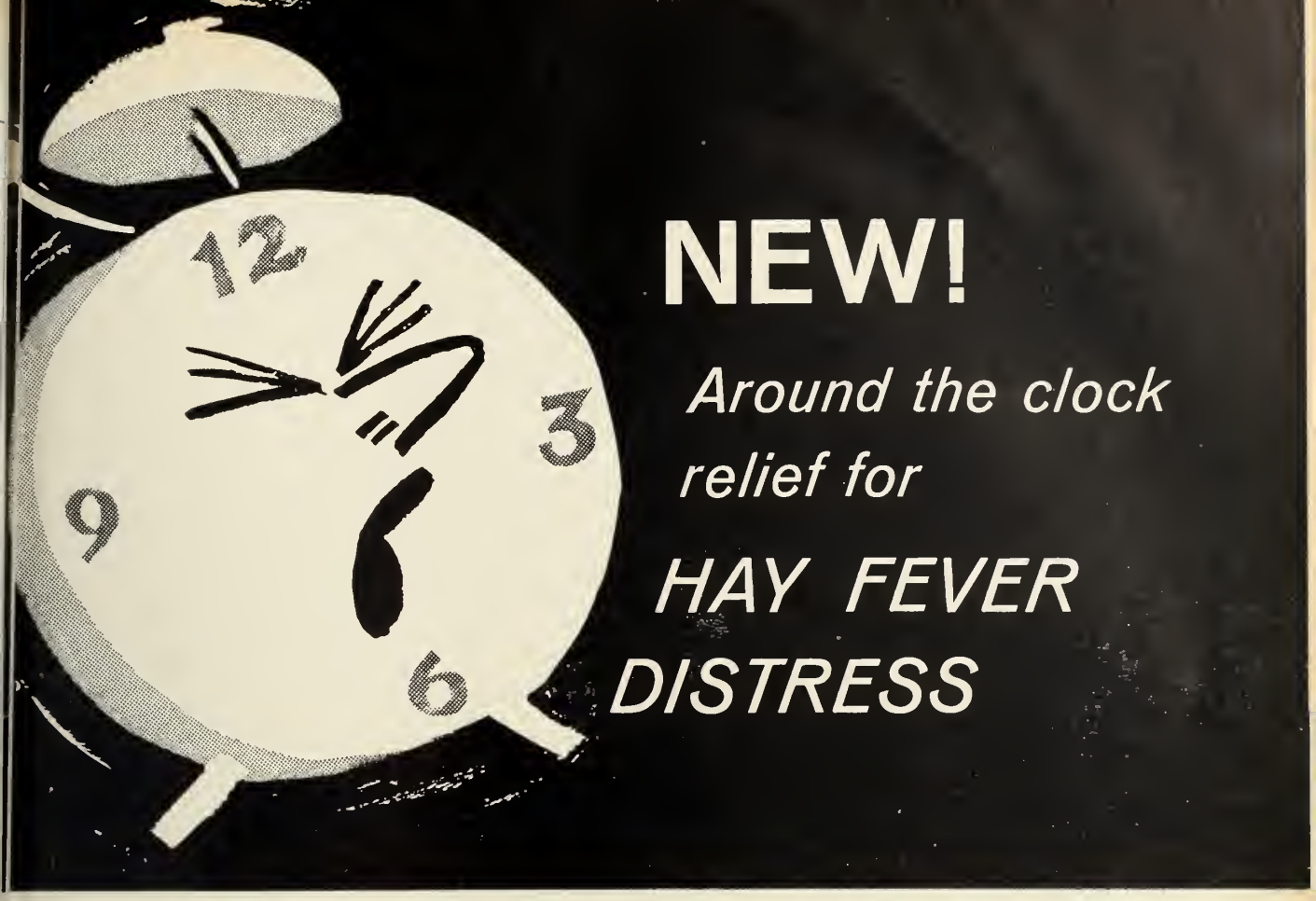
*(To Be Concluded in October Issue)*

**Addendum:** The flagpole described by Dr. Piercy is also a part of the heritage of the Ohio State Medical Association. At the meeting of the House of Delegates in Cincinnati on May 2, 1922, Dr. George W. Crile presented to the State Association a gavel inscribed as follows:

*"This gavel is made from the flag pole that carried the first American flag in Europe in the World War. Base Hospital No. 4, U. S. Army, Lakeside Unit.*

*Presented to*
*Ohio State Medical Association by*
*George W. Crile*
*June, 1920"*

This gavel has been the official gavel of the Association and has been used at the Annual Meetings since then. — Ed.




# NEW!

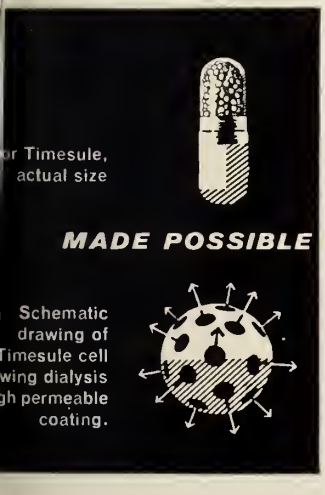
*Around the clock relief for*

*HAY FEVER DISTRESS*

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## *A NEW COMPREHENSIVE RELIEF*

- **Relief usually starts in minutes**—to open nasal passages, stop running nose and eyes, sneezing, wheezing, itching and post-nasal drip
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r Timesule, actual size

Schematic drawing of Timesule cell wing dialysis gh permeable coating.

***MADE POSSIBLE BY THE NEW TIMESULE RELEASE MECHANISM***

Release with the Isoclor Timesule is at a relatively even, constant rate, independent of gastrointestinal motility, pH, or enzymatic activity. Each Timesule pellet is actually a micro dialysis cell, consisting of a drug core with coating of dialyzing membrane of precisely controlled permeability. Approximately 20% of active drugs are released within one hour and 80% in 8 hours. Peaks and valleys of over-release and under-release are minimized for constant, controlled relief with minimum side effects.

**EACH ISOCLOR TIMESULE CONTAINS:**

Chlorpheniramine maleate . . . . . 10 mg.
d-Isoephedrine HCL . . . . . 65 mg.
In a special form providing prolonged therapeutic effect.

**DOSE:** Adults: One Timesule every 12 hours, or as directed.

**WARNING:** Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

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Mount Prospect, Illinois,



***For peptic ulcer gastric hyperacidity and gastritis...***

*In year-long study on peptic-ulcer patients*

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## Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

*Patients were followed for about one year.*

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

*Dosage:* Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

*Schwartz, I. R.:
*Current Therap. Res.* 3:29, Feb., 1961.

Winthrop Laboratories New York 18, N.Y.

Schering

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brand of trichlormethiazide

## to help them live with their hypertension

Good start on the day's work (sleep is restful, morning headache gone)



Golf today, fishing tomorrow (retired but not easily tired)



Housework in a.m., shopping in p.m. (B.P. down, dizzy spells relieved)



Gardening is enjoyable again (edema gone, spirits up)



often the only therapy needed to control blood pressure and relieve symptoms in mild or moderate cases*

NAQUA potentiates other antihypertensives when used adjunctively.... Side effects are minimal.... Economically priced.

Packaging: NAQUA Tablets, 2 or 4 mg., scored, bottles of 100 and 1000.

For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, New Jersey.

*Schaefer, L. E.: Clin. Med. 8:1343, 1961.

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Each Pulvule contains Pyronil® (pyrrobutamine, Lilly), 15 mg.; Histadyl® (methapyrilene hydrochloride, Lilly), 25 mg.; and Clopane® Hydrochloride (cyclopentamine hydrochloride, Lilly), 12.5 mg. Each pediatric Pulvule or 5-cc. teaspoonful of the suspension contains half of the above quantities. This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature.
Eli Lilly and Company, Indianapolis 6, Indiana.

Lilly

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Scientific Section

VOL. 58 SEPTEMBER, 1962 NO. 9

# Physiology of the Coronary Circulation

## Introduction to a Symposium

DONALD E. GREGG, Ph. D., M. D.

TO INTRODUCE this symposium, it is best, I believe, to define the objective of investigations of the coronary circulation. The objective of such studies is knowledge of the supply of oxygen to the myocardium, knowledge of the amount of uptake of oxygen by the myocardium and of its determinants when the ventricle is contracting as compared with that when it is relaxed, and finally, knowledge of the relation of such oxygen usage to cardiac work in states of normalcy, of increased or decreased stress, and of disease in man. There is no doubt that considerable progress is being made. It is only about 18 years ago that here in Cleveland it was first possible, with the use of the rotameter, to measure continuously coronary inflow in a preparation with some pretense to normalcy, namely the open-chest dog. A few years later, the introduction of the nitrous oxide method made available many quantitative estimates of coronary flow in resting man in diseased states and under a variety of normal and abnormal stimuli. Finally, within the last year, it has become possible to quantitate continuously coronary flow and myocardial metabolism in the conscious excited or strongly exercising dog, and in the presence of many other natural stimuli.

I will consider three points: (1) basic coronary data which the methodology has supplied, (2) the general patterns of response of the coronary circulation to changing systemic stress, and (3) recent findings in exercise and excitement. In each, emphasis will be placed on the events during a cardiac cycle.

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### Basic Coronary Data

Let us now look at some of the coronary flow data obtained under nearly basal hemodynamic conditions. Figure 1 shows the phasic flow during a cardiac cycle through the main left coronary artery and aorta, obtained two weeks postoperatively in a conscious and resting very large greyhound with a 300 Gm. heart, i. e., man's heart size. This is a retrace of an original record to remove other overlying curves not germane to this discussion. The blood pressure was taken through a catheter chronically implanted in the ascending aorta; the phasic left coronary artery flow and stroke cardiac output were taken by electromagnetic flow meters chronically implanted respectively on the main left coronary artery and the ascending aorta. With a mean aortic pressure of 105 mm. Hg, heart rate of 80, and stroke cardiac output of 35 cc.,

the left coronary flow is 2.8 cc. per beat or 225 cc./min. Mean coronary flow per 100 Gm. of myocardium and per heart beat of the same order of magnitude have been observed in resting man. The coronary inflow is phasically distributed with about 75 per cent occurring during diastole and 25 per cent during systole. By means of appropriate experiments in the open-chest dog, it has been demonstrated under a variety of stresses that 80-90 per cent of left coronary inflow is recovered in the coronary sinus, thus documenting the view that the product of left coronary inflow and the coronary arteriovenous oxygen difference can be used as an index of left ventricular metabolism.

Left ventricular oxygen usage in the resting dog such as for the greyhound whose coronary flow is illustrated in figure 1, approximates 22 cc./min. (225

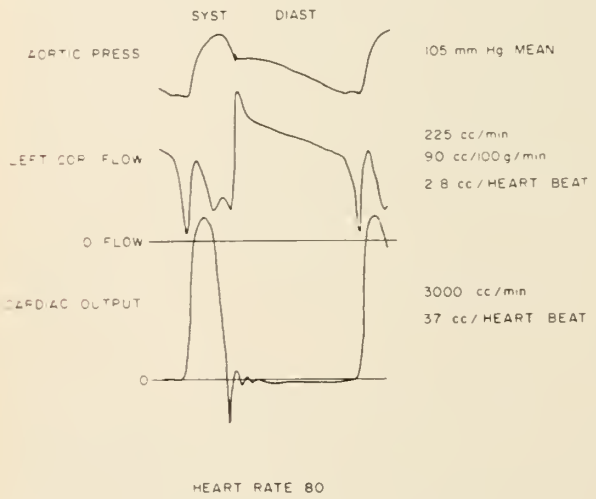



FIG. 1. *Reproduction of a retrace of an original record taken in the conscious resting dog 14 days postoperative showing phasic aortic blood pressure recorded by a strain gauge connected to a chronically implanted aortic catheter, phasic left coronary artery flow and stroke cardiac output by electromagnetic flow meters chronically implanted respectively on the main left coronary artery and ascending aorta.* (Khouri and Gregg, unpublished observations.)

cc. coronary flow times coronary A-V $0_2$ of 11 cc.). This is about 0.3 cc. per heart beat or 30 cc/100 Gm./min. The latter value approximates that found in resting man.

As is the left coronary inflow, so also the oxygen used by the myocardium appears to be fractionated between systole and diastole. In the open-chest dog, if the coronary arteries are perfused at a constant pressure and then the heart beat is stopped by vagal stimulation or intracoronary potassium injection, the oxygen used during the resulting prolonged diastole is of the order of 25 to 30 per cent of that used when the heart is beating. The oxygen used during such relaxation of the heart is presumably for activities not directly involved in the pumping process of the heart but rather for maintaining its cellular integrity and electrical activity.

This value for the resting oxygen consumption of the left ventricle does not seem to be related to the size of the heart, that is, the same value obtains when the ventricle is full of blood or is empty. On the other hand, if this heart is stressed with a high arterial blood pressure or with the injection of moderate amounts of epinephrine or norepinephrine, the oxygen used by the left myocardium at rest may be 50 per cent of that used when the heart is beating.

The preceding gives some idea of the basic coronary data and of the fractionation of the control of coronary flow and oxygen uptake within the myocardium during a cardiac cycle. The next considera-

## Coronary Symposium

On November 30, 1960, the Cleveland Area Heart Society presented an outstanding program entitled Coronary Artery Day. Dr. Gregg's is the first of the papers selected from that program, which will be presented as a symposium in this and the next issue of *The Journal*. Others contributing to this symposium are Drs. Arthur M. Master, Isidore Rosenfeld, F. Mason Sones, Jr., William Dock, Sylvester E. Gould, Armand A. Lefemine, Dwight Harken, David S. Leighninger, and Arthur Vineberg.

In addition to the papers appearing here, the program included one by Dr. Herman Hellerstein entitled "Electrocardiographic and Special Diagnostic Aids," one by Dr. John S. LaDue on "The Effect of Fibrinolytic Agents upon Experimental Myocardial Infarction," and one by Dr. Paul M. Zoll on "Anatomy of Coronary Artery Circulation." Dr. Charles P. Bailey was scheduled to speak on "Coronary Endarterectomy" but was unable to attend. The essayists participated in panel discussions entitled "Medical Therapy of Coronary Artery Disease," and "Medical-Surgical Panel Discussion of Coronary Disease" moderated by Dr. Henry A. Zimmerman and Dr. Earle B. Kay respectively.

Several of the authors have changed their manuscripts for publication as indicated by recent developments in this field. Those of Drs. Sones, Dock, and Gould are essentially abstracts of the papers read. Dr. Sones projected motion picture films illustrating his interesting work in coronary arteriography.

This program was arranged by a committee consisting of Dr. Donald Effler, Dr. Mason Sones, and Dr. Herman Hellerstein with Dr. Zimmerman as chairman, and Dr. Kay as adviser. We are grateful to the Cleveland Area Heart Society, to the committee, and to the essayists for the splendid cooperation they have given us in publishing the symposium.

THE EDITOR.

tion is concerned with the overall control of the coronary circulation.

## General Patterns of Response

A very large number of conditions affect the coronary flow and oxygen usage; almost none are without effect. Certain general patterns of response to primary changes of circulatory stress are discernible. The information which has been assembled from many laboratories has been obtained from both the resting human and the dog, and from the open-chest dog. It does not, however, contain information from normal humans and animals as to the regulation of the coronary circulation exposed to the stresses of everyday life such as exercise and excitement. For purposes of discussion, I direct your attention to the first column and to the last four columns of Table 1.

TABLE 1. *Patterns of response of the coronary circulation in man and dog to various physiological stresses.*

| Condition | Left Cor. Flow | Cor. A-V $O_2$ | Oxygen Usage | Art. B.P. / Stroke Cor. Flow | Stroke Cor. Flow | Stroke Cor. $O_2$ | Stroke Work |
|---|---|---|---|---|---|---|---|
| ↗ Blood $CO_2$ | → | → | → | → | → | → | → |
| ↗ CO (transfusion), Aortic Coarctation (mild), Cardiac Sympathetic Nerves, Catecholamines, Severe Anemia[1] and Hypoxia,[1] Thyrotoxicosis | ↗ | → | ↗ | ↘ | ↗ | ↗ | ↗ |
| Hypothermia, Shock (hemorrhagic), Heart Failure (extreme)[2] | ↘ | → | ↘ | ↗ (Hypo) ↘ (Sh) ? H.F. | ↘ | ↘ | ↘ |
| Hypertensive Cardiovascular Disease | → | → | → | ↗ | → | → | ↗ |
| Aortic Coarctation (complete), Aortic Stenosis, Pulmonary Stenosis | ↗ | → | ↗ | ↘ | ↗ | ↗ | ↘ |
| ↗ Heart Rate | ↗ | → | ↗ | ↗ | ↘ | ↘ | ↘ |
| Mild Ischemia, Anemia, Hypoxia | ↗ | ↘ | → | ↘ | ↗ | → | → |

1. Coronary A-V $O_2$ ↘ 2. Coronary A-V $O_2$ ↗

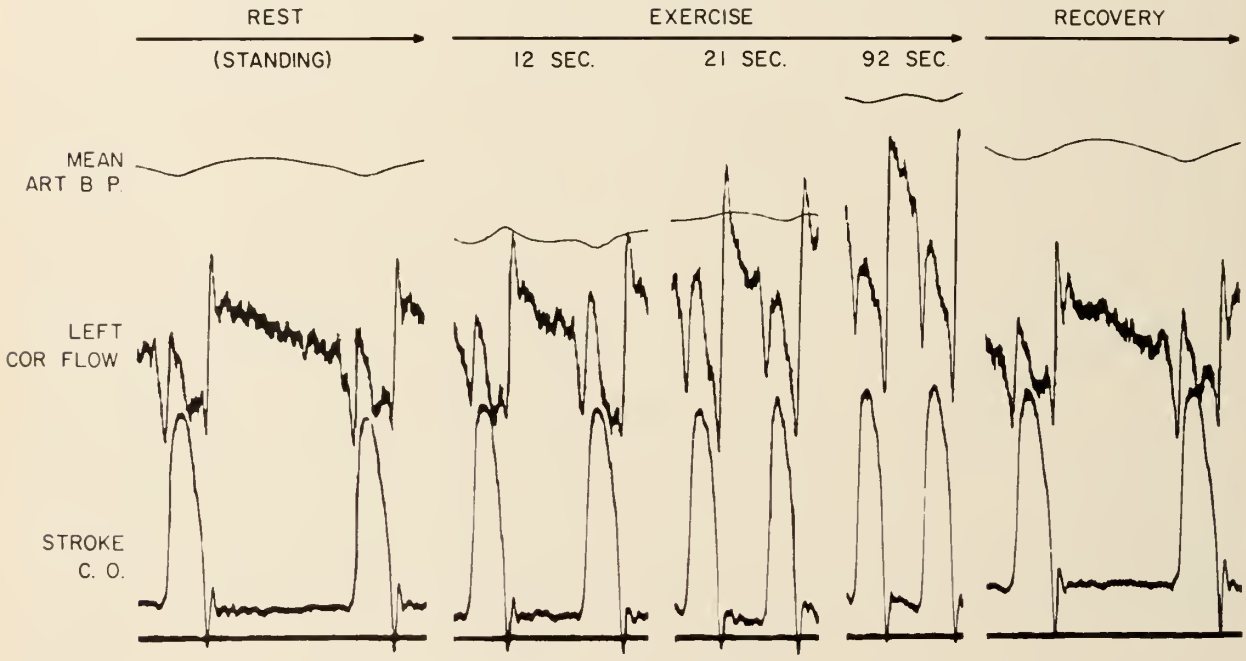
With a reasonable increase in arterial $CO_2$, with short periods of mild ischemia, anemia and anoxia, very little happens in the systemic or coronary circulation. When the primary increase in stress is a whole blood transfusion, aortic coarctation (moderate), cardiac action of fibers from the sympathetic nerves, injection of catecholamines, severe anemia or anoxia or thyrotoxicosis, there is an increase in stroke work and stroke coronary oxygen usage. Concurrently, stroke coronary flow increases while coronary vascular resistance decreases. In situations of primary decrease in stress such as hemorrhagic hypotension, hypothermia, and extreme heart failure, the stroke cardiac work and stroke coronary oxygen consumption decrease, as does the stroke coronary inflow. Similar changes occur with an increased heart rate caused by electrical stimulation. There are at least two exceptions to this general picture of coronary compensation to changing stress. One is that of chronic hypertension in which the stroke work is increased but stroke coronary flow and oxygen usage are unaltered while coronary resistance to flow increases. A second exception is that of complete aortic coarctation, aortic stenosis and pulmonary stenosis which may be characterized by a reduction in the stroke work of the heart, but at the same time the stroke coronary flow and stroke oxygen usage increase.

Is the statement justified that there is one controlling influence for coronary flow per heart beat; and also one dominant influence for oxygen usage of the left myocardium per cardiac cycle? This has been discussed and experimented upon for many years but I believe that as yet no final answer is available. The basic mechanisms affecting coronary flow and oxygen usage have been related experimentally to various parameters (Table 1). Directional changes in stroke coronary flow and stroke coronary oxygen are similar and, hence, can be considered together. The common directional change is so because normally most oxygen is removed from the coronary blood and the

level of coronary sinus oxygen is usually fairly constant under stress, i. e., it does not change more than 10 to 15 per cent. In those instances in which the coronary arteriovenous oxygen difference increases or decreases by this amount, it does not greatly affect the relation of coronary flow to oxygen usage since the change is very small relative to the magnitude of the coronary flow change. But this does not document a functional correlation between these parameters. With a variety of conditions of changing systemic stress, the stroke coronary flow and stroke coronary oxygen correlate fairly well with the stroke work. The exceptions constitute a group of conditions in which the outflow channels of the two ventricles have been restricted in some manner. In these one can show excellent correlation of the flow and oxygen usage with the mean systolic arterial blood pressure.

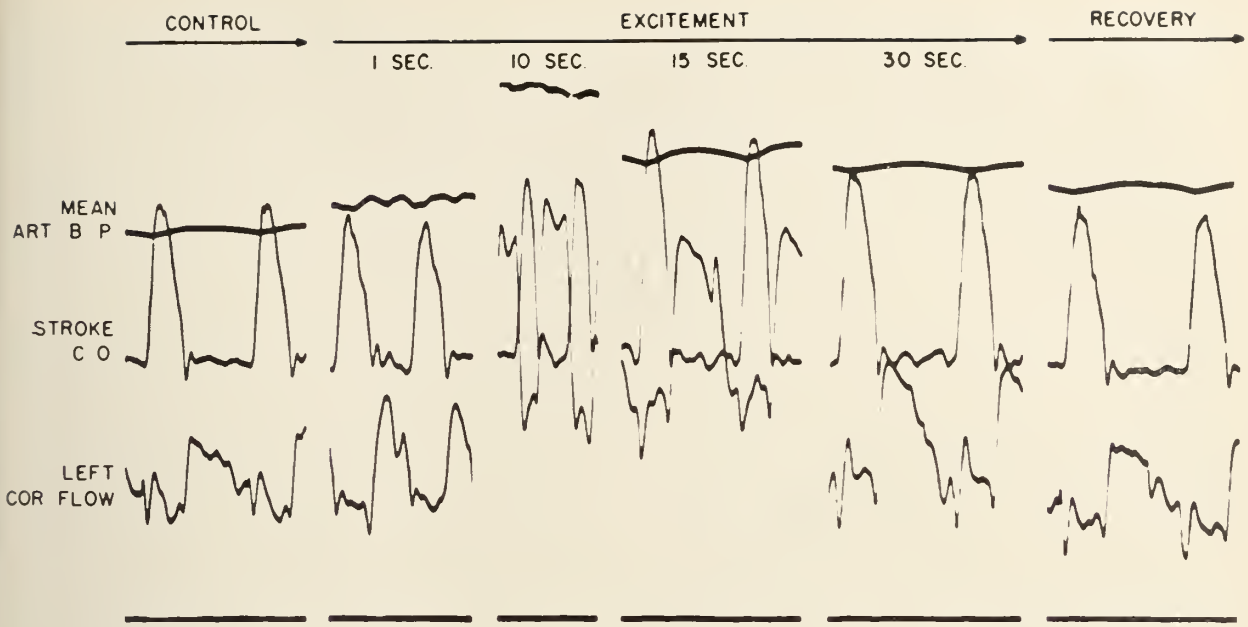
In addition, there is quite a list of determinants that have been thought to be fundamental. Attempts have been made to relate coronary flow and oxygen usage to the mean arterial blood pressure, mean systolic arterial blood pressure, mean systolic pressure times the duration of systole, ventricular filling pressure or mean atrial pressure, ventricular diastolic volume or fiber length, tension within the ventricular wall, oxygen tension of the arterial blood, oxygen tension within the myocardium, action of local metabolites or vasodilating substances. Possibly, the best correlation of all should be with the reduction of cytochrome oxidase and the needs of the hydrogen transport system.

To summarize, final decision as to whether any of these determinants of coronary flow or oxygen usage is primary or empirical, must await the necessary measurements under normal conditions of stress without anesthesia or surgical insult. I do not expect that new parameters of control will necessarily exist in the stresses imposed by everyday life but it is quite possible that their weighting will be quite different. For example, in exercise and excitement the heart rate is largely increased. It is disturbing that in only one of all the conditions of stress in which the heart




| | | | | | |
|---|---|---|---|---|---|
| HEART RATE | 78 | 129 | 180 | 214 | 87 |
| BLOOD PRESS. | 99 | 80 | 84 | 125 | 110 |
| MEAN COR. FLOW | 285 | 320 | 484 | 528 | 297 |
| STROKE COR. FLOW | 3.6 | 2.5 | 2.7 | 2.5 | 3.4 |
| CARDIAC OUTPUT | 2948 | 5405 | 6800 | 8996 | 3251 |
| STROKE VOLUME | 38 | 42 | 38 | 42 | 38 |

FIG. 2. *Reproduction of sections from a continuous record showing the effect of treadmill exercise on mean arterial pressure, stroke left coronary inflow and stroke cardiac output, using strain gauge and electromagnetic flow meters as in Figure 1. Large greyhound dog.* (Khouri and Gregg, unpublished observations.)




| | | | | | | |
|---|---|---|---|---|---|---|
| HEART RATE | 128 | 188 | 265 | 132 | 112 | 118 |
| BLOOD PRESS. | 88 | 103 | 173 | 133 | 124 | 112 |
| MEAN COR. FLOW | 144 | 174 | 408 | 402 | 212 | 132 |
| STROKE COR. FLOW | 1.13 | 0.95 | 1.54 | 3.05 | 1 89 | 1 12 |
| CARDIAC OUTPUT | 7232 | 10349 | 8291 | 8408 | 7115 | 6468 |
| STROKE VOLUME | 57 | 55 | 31 | 64 | 64 | 55 |

FIG. 3. *Reproduction of sections from a continuous record showing effect of excitement (loud noise) on mean arterial pressure, stroke cardiac output and stroke left coronary flow using strain gauges and electromagnetic flow meters as in Figure 1. Large greyhound dog.* (Khouri and Gregg, unpublished observations.)

rate increases, do the stroke coronary flow and stroke coronary oxygen increase (Table 1). This is in thyrotoxicosis. In the others, stroke coronary flow and stroke coronary oxygen decrease. This would mean that coronary flow and oxygen usage are completely limited by the heart rate. For example, if the heart rate is tripled, coronary flow can only be increased three times. I do not believe my heart works in this way but rather that additional mechanisms can increase the coronary flow per heart beat. At all events, the point I am trying to make is that great caution is needed in transferring results from anesthetized and traumatized animals to humans.

## Recent Findings in Exercise And Excitement

A start is being made in alleviating this situation. Successful direct measurements of coronary flow have been made in normal unanesthetized and active dogs during the last year by applying chronically an appropriate electromagnetic flow meter (a somewhat modified Kolin type) directly to the coronary arteries. Phasic flow measurements have been made in the left circumflex coronary and in the main left coronary artery. A large electromagnetic flow meter implanted on the ascending aorta gives simultaneous cardiac output per heart beat, and an indwelling polyvinyl tubing through the wall of the central aorta gives blood pressure values.

Initially the flow transducer was placed on the left internal mammary artery anastomosed to the left circumflex coronary artery. This was done so that the meter would be off the surface of the heart in a region without mechanical activity. The first anastomoses were by means of a suture technic with coronary perfusion support, but there was a high level of surgical mortality and postoperative thrombosis of the 35-40 per cent of dogs that survived a long time. Most had occlusion at the level of the anastomosis with a large development of the coronary collateral circumflex. In the second group of dogs, a highly successful non-suture technic was employed. Only three dogs (of 33) developed postoperative thrombosis. The rest were sacrificed 14 to 24 months post-

operatively. Prior to sacrifice, an appropriate small flow meter was placed on the anastomosed internal mammary artery and the dogs studied for periods up to two months (these experiments not reported here). For measurement of the left coronary flow (reported here), a flow probe of aspirin size was placed directly on the main left coronary artery which is about 2½ mm. long. In these dogs, a reference coronary flow zero was obtained when desired by occluding the coronary artery for 5 seconds or so by snares chronically implanted around the left circumflex and left descendens branches just beyond the probe. Since it was not possible to occlude the septal artery, the flow zero is 10-15 per cent too high.

It appears that the response of the coronary circulation of the dog to exercise differs from that to excitement. Strips of record in figure 2 illustrate the main left coronary flow, mean aortic pressure, and stroke cardiac output at standing rest, after 12 seconds, 21 seconds, and 92 seconds of moderate exercise, and during recovery. As the heart rate almost triples, the blood pressure rises mildly, the stroke cardiac output remains essentially unchanged while the mean coronary flow doubles. Despite this, the stroke coronary flow does not increase but decreases mildly. This suggests that the coronary flow is limited by the heart rate. I suspect, however, although as yet I cannot prove it, that with quite heavy exercise the coronary flow per heart beat will rise. At all events, the fact that the stroke coronary flow decreases rules out as a determinant of coronary flow any factor that rises in exercises such as the systolic or diastolic blood pressure, or possibly ventricular tension.

In the experiment illustrated in figure 3 in which the dog at standing rest was excited by a loud and sharp noise, the coronary response is different from that with moderate exercise. As the heart rate and blood pressure are greatly increased, the stroke cardiac output is only temporarily changed (decreased), while the mean coronary flow triples. In contrast to exercise, the stroke coronary flow is greatly increased. In this instance, the stroke coronary flow might very well correlate with the systolic pressure, diastolic pressure or the intraventricular tension.

The results presented are just a beginning of an attempt to study the reactions of the coronary circulation in the unanesthetized state to normal stimuli. They indicate a different response to exercise and excitement. The coronary response to excitement of increased stroke coronary flow with increased heart rate has not been observed to occur in anesthetized open-chest dogs and stresses the caution that is necessary in using data obtained in the latter preparation as a guide to understanding events in the normal dog.

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**EFFICACY OF HEPARIN** and of the oral anticoagulants in the management of acute myocardial infarction and the acute coronary insufficiency syndrome is compared in this long term (average 15-16 day) study. No statistical difference was found when the heparin group was compared to the oral-anticoagulant group with regard to morbidity and mortality. Adequate anticoagulation control was easier to achieve with heparin than with an oral anticoagulant, and maintenance of control was equally easy in the two groups.

Heparin, 150 to 200 mg./cc, was injected subcutaneously every 12 hours. Control of heparin dosage was simplified by using the plasma recalcification test. Since the administration of 150 mg. of heparin every 12 hours uniformly produces satisfactory anticoagulant effect without manifestations of hemorrhage, regular constant laboratory controls of heparin do not seem necessary. Perhaps the recalicification time should be determined once or twice at the onset of heparin therapy so that possible hyperreactors might be eliminated, but this is not uniformly necessary.—ABSTRACT: Earle E. Schumacher, Jr., M. D.; James R. Drake, M. D., and L. H. Feenstra, M. D., Grand Rapids, Mich.: *American Journal of Cardiology,* 9:568-575, (April) 1962.

# The Master Two-Step Test

## Use in Diagnosis of "Incipient" Coronary Artery Disease

ARTHUR M. MASTER, M.D., and ISIDORE ROSENFELD, M.D.

IN REVIEWING aids in the diagnosis of coronary artery disease, several points which stress the value of an exercise test for cardiac function deserve emphasis. Of these, the first to be stressed is the importance of chest pain or pressure since a more important symptom or signal complaint does not appear in medicine. Second, it should be realized that a normal resting electrocardiogram does not exclude coronary disease. Third, one frequently cannot differentiate angina pectoris from extracardiac pain by the history alone. Fourth, there is need for standardization in the exercise test. These problems are, we believe, solved by the "2-step" test. Finally, new criteria for the evaluation of the "2-step" test have been developed during the past two years particularly with reference to the "false negative," the "false positive" tests, and the RS-T segment depression. The true *"ischemic"* change, the "j," *junctional* or functional alteration, the *QX/QT* ratio, and the *Q-T* measurement have also been investigated and criteria established for their significance.

One need hardly emphasize the importance of chest pain as a chief complaint.[1] In a series of 612 consecutively studied patients with heart disease, chest pain was an important, if not the most important, complaint in three fourths of the patients with cardiac diseases and, when coronary disease alone was analyzed, 90 per cent of the patients presented with this sensation.[2]

A negative resting electrocardiogram does not exclude coronary disease or any significant heart disease. The *normal resting electrocardiogram* simply implies that the heart is adequate while the patient is resting on the examining table. Paul Wood has observed that 70 per cent of his patients with angina pectoris possessed normal resting electrocardiograms.[3] The percentage in our own series is between 40 and 50 per cent. In other words, then, although it is good to possess a normal electrocardiogram at rest, it definitely does not exclude significant coronary disease.

One might next inquire whether a *detailed history* would make the diagnosis of angina pectoris. That the patient's history is extremely helpful, there is no question, but we have always strongly felt that often one cannot make the diagnosis on the patient's story, even though it is obtained most carefully. In 10 to 40 per cent of patients, the usual criteria evaluated in distinguishing anginal syndrome from extracardiac functional disease may not be helpful.[1] Thus, let us consider the role of effort in those with chest pain or pressure caused by coronary disease. By pain we mean "pressure," "squeezing," "discomfort," or any one of many terms employed by the patient to describe a chest complaint. In 9 per cent in one series studied,[1] the patients could perform even strenuous effort such as climbing, walking up a hill against the wind or in the cold, and walking after a meal, without bringing on the symptom. Another 23 per cent developed chest pain only on unusual effort, for example, climbing hills or walking after meals. Only 68 per cent developed chest pressure on usual moderate activities such as walking. Hence, the response to effort does not always distinguish angina pectoris from chest or arm sensations due to extracardiac causes; nor will the response to nitroglycerin.[1] In 27 patients who were free of heart disease but in whom chest complaints of one sort or another were present, nitroglycerin was employed as a test, repeatedly, in the same patient. Ten obtained relief. It is well known that those with arthritis, gallbladder or renal colic, ulcer, and hiatus hernia have found relief with nitroglycerin in a fair percentage of the cases.

As a final argument for a cardiac functional test, it should be stressed that in a large number of people with significant coronary disease, there is no complaint at all, and therefore, in a routine examination in a doctor's office, a functional test of the heart is invaluable. This is particularly the case in periodic examinations of executives, military personnel (e. g. pilots), civil employees, and life insurance applicants.

We would now like to detail the necessity for standardization of a functional test. When the "2-


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FIG. 1. *The "two-step" exercise test in progress. Essentials for the test are: direct writer electrocardiograph, "two-step" apparatus, sweep-second hand clock. Electrodes are attached to the patient who holds the lead wire cable during the test. A complete trip consists of an ascent of the two steps and a descent to the other side.*

step" test was evolved at Cornell University Medical College in the years 1925-29, after experimenting with scores of combinations in relation to the height of the steps to be climbed, the duration and the speed of exertion, and the type of exercise, we found that two steps, each 9 inches high, were most practical (Fig. 1). The patient rested for an appreciable instant at the end of each trip. Hence, if he performed a double (3 minute) test, climbing, let us say, 36 trips or 72 steps, it was not as difficult as ascending 72 steps steadily, that is, without rest. In the Master "2-step" exercise, the patient turns around at the end of each trip, namely, at the completion of each two steps he takes. It was observed, in 1925-29, that cardiac efficiency in foot pounds of work per minute, varied with sex, age, and weight.[4,5] Men could perform more work than women; the lighter person could make more trips than the heavier. For men, the most efficient weight was about 155-165 pounds, and for women, about 135-145 pounds. The optimum work was about 3700 foot pounds per minute in men, at ages 21 to 30 years. Women could not do as much and their optimum was about 3100 foot pounds per minute. As one grew older, he no longer was as efficient as a younger person even though quite healthy. In the early years with the "2-step" test, we employed blood pressure and pulse response as criteria; in 1941, for many reasons, we changed to the electrocardiogram and we have ever since found it most satisfactory.[6] Actually, we had already done this since 1925 but only in 1940 were we convinced that the post-exercise electrocardiogram was preferable to the labile blood pressure and pulse rate.

Tables were published establishing the number of trips performed in one and one-half minutes, according to the patient's age and sex and weight.[4,5] However, now we double the number of trips and thus employ the double or three minute test. For life insurance, for periodic executive health, for military examinations, etc., the three minute test is always used (Table 1). In our own private practice we do it this way at least 90 per cent of the time. The

TABLE 1. *"Master Two-Step Test" Standardized by Age and Weight*

**Trips Performed In Master Double (3 minute) Two-Step Exercise Test***
**Males and (Females)**

| Weight | Age In Years | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 | 75-79 |
| lb. | | | | | | | | | | | | | |
| 50 - 59 | 64(64) | | | | | | | | | | | | |
| 60 - 69 | 62(60) | | | | | | | | | | | | |
| 70 - 79 | 60(58) | | | | | | | | | | | | |
| 80 - 89 | 58(56) | 58(56) | 58(56) | 56(54) | 54(52) | 54(48) | 52(46) | 50(44) | 50(42) | 48(42) | 46(40) | 46(38) | 44(36) |
| 90 - 99 | 56(52) | 56(54) | 56(52) | 54(50) | 54(48) | 52(46) | 50(44) | 50(44) | 48(42) | 46(40) | 44(38) | 44(38) | 42(36) |
| 100 - 109 | 54(50) | 56(52) | 56(52) | 54(50) | 52(48) | 50(46) | 50(44) | 48(42) | 46(40) | 44(38) | 44(36) | 42(36) | 40(34) |
| 110 - 119 | 52(46) | 54(50) | 54(50) | 52(48) | 50(46) | 50(44) | 48(42) | 46(40) | 46(38) | 44(36) | 42(36) | 42(34) | 40(32) |
| 120 - 129 | 50(44) | 52(48) | 54(48) | 52(46) | 50(44) | 48(42) | 46(40) | 46(38) | 44(38) | 42(36) | 40(34) | 40(32) | 38(30) |
| 130 - 139 | 48(40) | 50(46) | 52(46) | 50(44) | 48(42) | 46(40) | 46(38) | 44(38) | 42(36) | 40(34) | 40(32) | 38(30) | 36(30) |
| 140 - 149 | 46(38) | 48(44) | 50(44) | 48(42) | 48(40) | 46(38) | 44(38) | 42(36) | 40(34) | 40(32) | 38(32) | 36(30) | 36(28) |
| 150 - 159 | 44(34) | 48(42) | 50(40) | 48(40) | 46(38) | 44(38) | 42(36) | 40(34) | 40(32) | 38(32) | 36(30) | 36(28) | 34(26) |
| 160 - 169 | 42(32) | 46(40) | 48(38) | 46(38) | 44(36) | 44(36) | 42(34) | 40(32) | 38(32) | 36(30) | 36(28) | 34(26) | 34(24) |
| 170 - 179 | 40(28) | 44(38) | 46(36) | 46(36) | 44(34) | 42(34) | 40(32) | 38(32) | 36(30) | 36(28) | 34(26) | 34(26) | 32(24) |
| 180 - 189 | 38(26) | 42(36) | 46(34) | 44(34) | 42(34) | 40(32) | 38(32) | 38(30) | 36(28) | 34(28) | 32(26) | 32(24) | 30(22) |
| 190 - 199 | 36(24) | 40(34) | 44(32) | 42(32) | 42(32) | 40(30) | 38(30) | 36(28) | 34(26) | 32(26) | 30(24) | 30(24) | 28(22) |
| 200 - 209 | | 38(32) | 42(30) | 42(30) | 40(30) | 38(28) | 36(28) | 34(26) | 32(26) | 32(24) | 30(22) | 28(22) | 28(20) |
| 210 - 219 | | 36(30) | 42(28) | 40(28) | 38(28) | 36(26) | 34(26) | 34(26) | 32(24) | 30(22) | 28(22) | 28(22) | 26(20) |
| 220 - 229 | | 34(28) | 40(26) | 40(26) | 38(26) | 36(26) | 34(24) | 32(24) | 30(22) | 28(22) | 26(20) | 26(20) | 24(18) |

*Reprinted from *New York State J. Med.*, 61:1850 (June 1) 1961.

test, of course, is only performed when the resting electrocardiogram is normal. In spite of this, if severe coronary disease is suspected, only a "single" or one and one-half minute test is done. The *test is completely safe* if one makes certain that the resting electrocardiogram is completely normal, that the patient is not acutely ill, and that he is told before he begins the exercise to stop immediately if any chest, arm, neck, or jaw sensation appears during the exercise.

In regard to the importance of *standardization,* Yu and his co-workers,[7] and Rumball and Acheson[8] revealed that excessive exercise in normal people could produce "significant" RS-T depressions in the electrocardiogram, namely, "ischemic" or horizontal or sag changes. Hence, if one proceeds beyond the exertion indicated in the published tables, one may occasionally observe changes in normal people. And, certainly, it is dangerous to overexert a patient who may have significant coronary artery disease. Hence, standardization is conducive to safety. To illustrate the necessity for standardization of the "2-step" exercise, let us cite the case of a man with severe anginal syndrome and whose resting electrocardiogram was entirely negative.[9] He walked the single (one and one-half minute) test, which consisted of 23 trips, and there were "ischemic" RS-T segment depressions, both horizontal and "sag" (Fig. 2). The electrocardiogram revealed no RS-T depression at all when 10 trips one day, 14 trips the next, and 18 trips the next, were performed in the same time of one and a half minutes. Only when he walked 21 trips did any evidence appear of beginning RS-T changes. Hence, only the full number of climbs, as delineated in the published table, produced the unequivocally abnormal test.

In evaluating drugs, standarization is essential in order to compare the results of physiologists and pharmacologists in any part of the world. Thus, in our study of iproniazid (Marsilid®) for relief of the anginal syndrome, we learned that the pain or pressure very frequently completely and dramatically disappeared in many cases of status anginosus but, nevertheless, after months of treatment the same ischemic RS-T depression appeared in the postexercise electrocardiogram and once the drug was no longer prescribed, the angina pectoris returned.[10] This strongly indicated that the drug had no effect on the

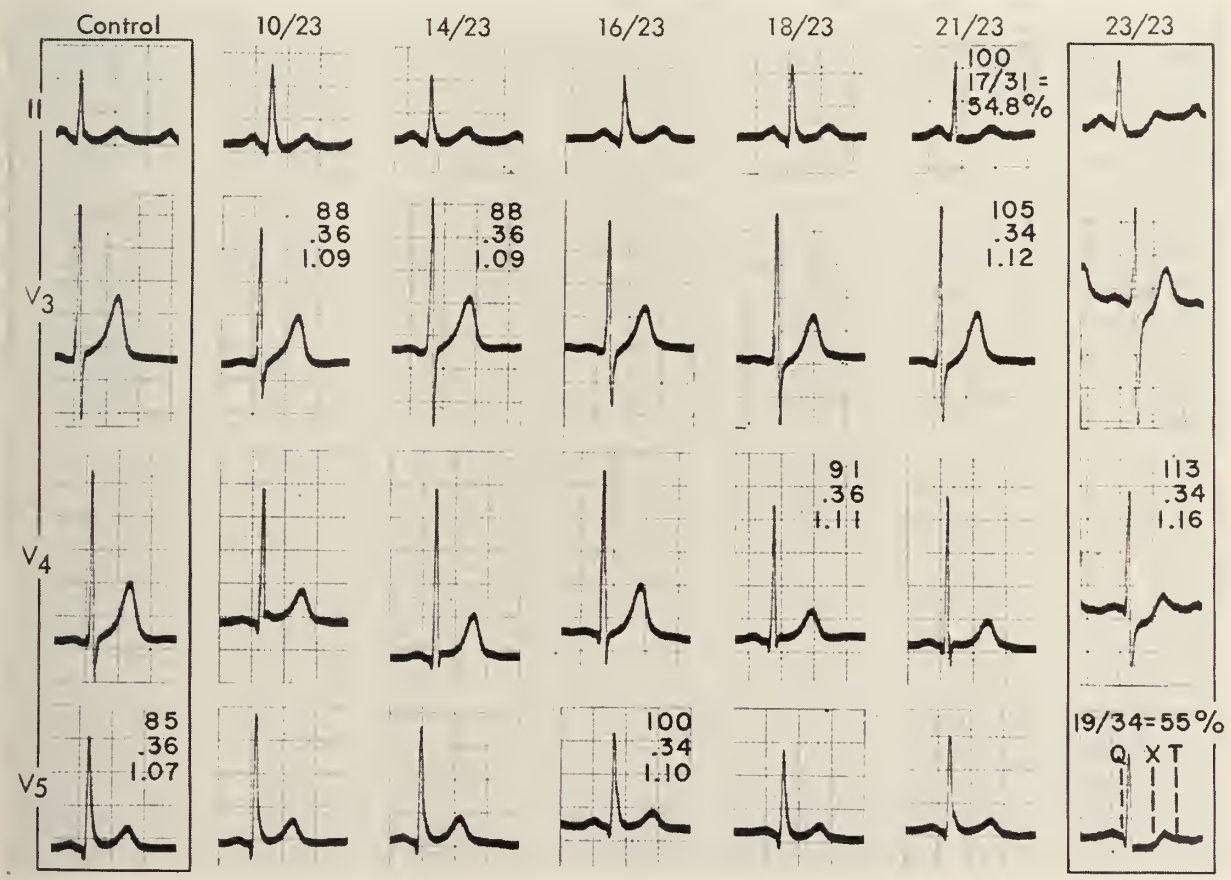



FIG. 2. *A 42 year old man with severe angina pectoris. The 12-lead resting electrocardiogram normal but the postexercise single (1½ minute) test (last column) discloses "ischemic" RS-T depressions in Lead $V_5$ with prolongation of the QX/QT fraction to 55 per cent. The QT ratio is prolonged, in lead $V_4$, to 1.16. Note the findings in the "partial" tests, that is, when 10, 14, 16, and 18 trips were performed, each in 1½ minutes. Only when 21 trips were essayed do changes begin to appear (leads II and $V_3$). Unequivocal "ischemic" changes are observed when the full 23 trips, called for in the table, were performed (last column). With the increasing work load, the QT ratios lengthened progressively. The series of 3 numbers, arranged in columns, represent, respectively, the heart rate, actual QT, and finally, the QT ratio.*

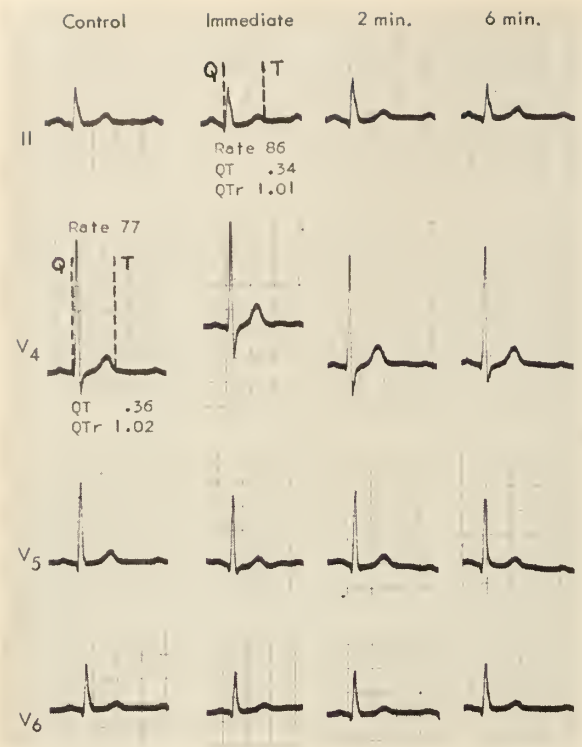



FIG. 3. *A 54 year old man with upper sternal and neck pressure. The 12-lead control is normal (only leads II, $V_{4,5,6}$ shown) and the double ( 3 minute) "2-step" test is negative. Spondylitis, with marked degenerative changes between $C_4$ to $C_7$ was found.*

underlying coronary artery disease. Unless a common base is employed, one investigator cannot compare his results with another.

When the postexercise electrocardiogram doesn't change, that is when there is no depression of the RS-T segment below the baseline, it is particularly meaningful since a *negative double (three minute) two-step test* strongly indicates that the patient does not have heart disease. This, in our past experience, has been true in all but about 3 per cent of instances. In the latter cases, the so-called "false negatives," we have further demonstrated that the Q-T measurement, i. e., the duration of electrical systole, a new refinement for the "2-step" test, will diminish, if not obviate almost completely, the number of "false negative" tests.[11-16]

The work of Robb at Metropolitan Life Insurance Company[17] and of Mattingly at the Walter Reed Hospital,[18] confirm the importance of a negative double "2-step" test. With ischemic RS-T depression, a large number died or developed episodes of acute coronary occlusion in their 4 to 11 year follow-up of military personnel and insurance applicants, whereas, when the three minute test was completely negative, the number of deaths of heart attacks or cardiac deaths were no more than good insurance risks suffered. This is statistical confirmation of the value of a normal or negative double (three minute) Master "2-step" test.

We could illustrate the value of a negative double "2-step" test by many examples. In one patient with no change in the postexercise electrocardiogram, a severe spondylitis was found (Fig. 3). To mention just a few of many similar instances, gallstones were discovered in another patient and, in still another, a hiatus hernia.

In this report we must stress again that, in every instance, the resting electrocardiogram was completely normal before the "2-step" test was essayed. There were no RS-T depressions, T-wave inversions, deep Q-waves, bundle branch block, or Wolfe-Parkinson-White patterns.

To evaluate our new criteria for the exercise test, we analyzed the last 596 consecutively performed "2-step" tests. There was no postexercise RS-T depression in 277, that is, the *double "2-step" was negative.* Only in 3.2 per cent were there "false negatives," eight men and one woman. In other words, in only nine patients did heart attacks appear within a period of three to seven years. These results in themselves are exceptionally good and, as we have shown, they have been fully corroborated by Robb[17] and by Mattingly.[18] Recently, Franco found only 1½ per cent "false negatives" in 408 employees with no RS-T depression.[19]

We feel that even the 3.2 per cent of "false negatives" can be reduced by further study. Thus, the QT interval should be measured in those instances of a negative test in which history, physical finding or laboratory observation is suggestive of heart disease.

There is another new parameter which we employ in formulating criteria of our "2-step" test. Lepeschkin and Surawicz have reported on the *QX/QT fraction* when there is a postexercise RS-T segment depression[20] (Fig. 4). They found it of doubtful value. However, we have investigated this and believe it to be of definite importance.[21] Employing the terminology of Lepeschkin and Surawicz, the QX, which measures the duration of the RS-T depression in seconds, divided by the entire duration of ventricular systole, that is, the QT interval, gives a ratio. If this ratio is more than 50 per cent, it suggests organic heart disease and when it is under 50 per cent, it is excellent corroborative evidence for the absence of significant alteration in coronary artery flow. This holds in 95 per cent of the cases of RS-T segment depression in those with organic disease,

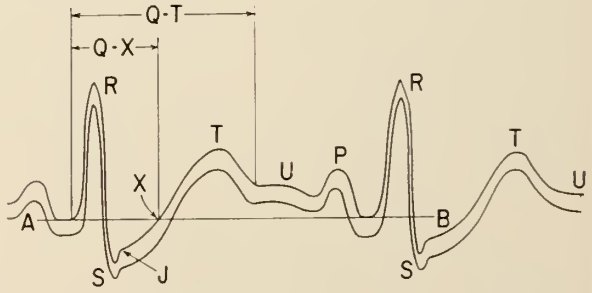



FIG. 4. *Modified from Lepeschkin, E., and Surawitz, B. New England J. Med., 258:511, 1958.*

male or female, and also in men, even with extracardiac causes of chest or arm symptoms.

The first parameter mentioned was the *QT interval* or measurement of duration of ventricular systole. For several years, innumerable workers have made this simple evaluation but only a few have studied the effect of exercise, and none in any standardized test, like the "2-step" exercise test. We have corroborated its importance in every one of the 596 men and women who consecutively performed the "2-step" test. The actual QT, corrected for the heart rate, is compared with the "ideal" or "normal" QT obtained from published tables and nomograms. To obtain this "ideal" or "normal" QT value we employ the formula by Bazett.[11] This is $K\sqrt{R-R}$, a constant, times the square root of the cycle length in seconds. We have used, as Bazett, and others have, $K = .40$.[12-14,16,22] If the fraction is 1.08 or more, the actual QT is considered abnormal. We have employed the Welsh "QT Calculator" (Fig. 5), a small 15 centimeter rule, to simplify the calculation and we have found it completely accurate.* It requires a few minutes to perform the calculations, that is, to obtain the heart rate in the postexercise electrical tracing and to compare the actual or measured QT with the ideal QT. We will present our data shortly concerning a large experience in both normal people and those with heart disease. Digitalis, quinidine, and electrolyte disturbances alter the length of the QT, so the latter study should be made in the absence of these drugs.[23]

Of the nine subjects with "false" negative double "2-step" tests, those eight that developed heart attacks had prolonged or abnormal QT duration and, therefore, only one of the 277 was a "false" negative, utilizing the newer criteria. If our results are corroborated, it appears that almost perfect diagnostic accuracy can be obtained when the postexercise electrocardiogram demonstrates no RS-T segment depressions, that is, there will be no significant coronary disease in such patients.

With regard to the character of RS-T depression, many authors in the past, particularly Paul Wood of England,[3] Robb in this country,[17] and also Mattingly,[18] have emphasized that an *"ischemic"* depression, that is, an absolutely horizontal depression or an actual "sag" (Fig. 6), signified heart disease and that a *"j" or junctional* depression (Fig. 6) was of no or little significance and therefore indicated a "functional" alteration. We do not agree with this interpretation of the "j" or junctional depression[16,24,25] but we have confirmed the significance of the *"ischemic" RS-T depression.* When the depression is truly horizontal or sags, without any further measurement, it would, in 95 per cent of the patients, be indicative of heart disease or, at least, of significant interference with the coronary circulation or of myocardial nutrition. This is particularly the situation when, in the presence of any type of RS-T depression, "ischemic" or "j," the QX QT fraction, and the corrected QT interval are abnormal. Conversely, if these values together are within the normal range, the patient does not have heart disease.

The measurement of the QX QT is even simpler than that of the QT ratio (QTr). The straight edge of a card or piece of paper is placed along the isoelectric level, that is, on the top edge of the P-R segment between two completely level beats. We mark the beginning of the Q, then the X or the point

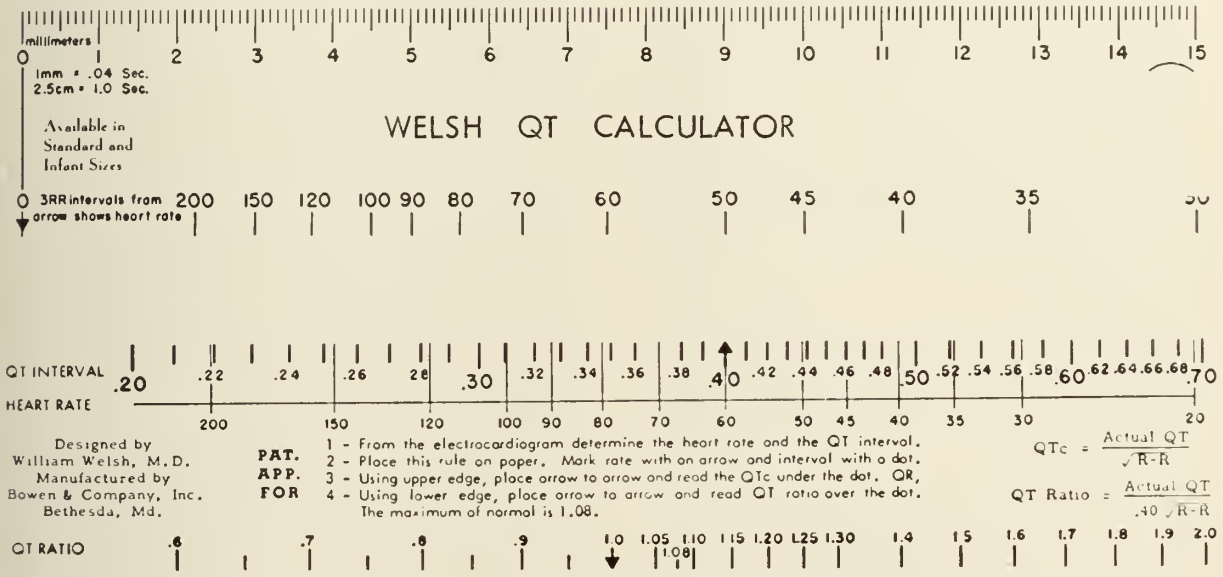



FIG. 5. *"Welsh QT Calculator." One side of the rule measures the heart rate easily and accurately. The opposite edge is calibrated into millimeters. The second side of the rule demonstrates, on one edge, the QT interval for a definite heart rate. The other edge presents the QT ratio, that is, the ratio of the actual QT to what the QT should be for the specific heart rate.*

*Sold by the Bowen & Company, Inc., Bethesda, Maryland.

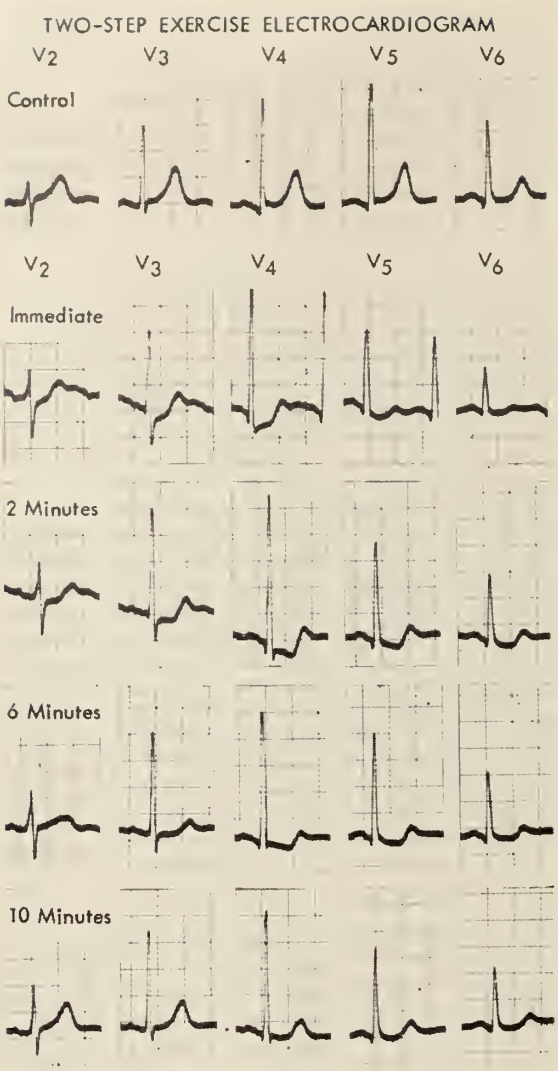



FIG. 6. *A 65 year old man with severe anginal syndrome.* "ISCHEMIC" *depressions are observed in the 2 minute post-exercise tracing (leads $V_3$ through $V_6$) and in the 6 minute tracing (leads $V_4$ and $V_5$). The "j" or junctional depressions are present in the immediate tracing (leads $V_{2,3,4}$) and in the 2 minute tracing (lead $V_2$). "Miscellaneous" or other configurations are seen in the immediate tracing (leads $V_{5,6}$), the 2 minute tracing (lead $V_6$) and the 6 minute tracing (lead $V_6$).*

at which the RS-T depression returns to that baseline, and, finally the end of ventricular systole, that is, the end of the T-wave. The eye alone will often tell one if QX is more than half the QT duration. Here, too, the same Welsh "QT Calculator" may be utilized since one edge is a millimeter rule and therefore presents the same ruling as the ordinary electrocardiographic vertical time markings. If the QX/QT fraction is more than half, that is, more than 50 per cent, it is considered an abnormal response and if it is less than this, it is evidence against the presence of cardiac involvement.

Of the RS-T depressions in the 596 consecutively performed "2-step" tests summarized in this article, there were 319 tests with RS-T depressions. Let us now consider the *"j" or junctional RS-T alteration* in these patients. In a "j" or junctional depression, it is only the "j" that is genuinely depressed since the RS-T rises to the baseline without ever remaining on the level or horizontal at all. We do not agree with those who say that a junctional alteration is of no importance and signifies a functional change.[26] In 30 per cent of the "j" cases, the RS-T depression was present in people who had heart disease (Fig. 7).[9,15,16,21,25] Therefore, in all "j" depressions, men or women, the QX/QT ratio should be obtained and the QTr calculated. If the former is less than one-half and if the QT ratio is 1.07 or less, the "j" is functional in origin (Fig. 8). If the QX/QT is more than 50 per cent and the QT ratio increased to 1.08 or beyond, heart disease is present. However, if the "j" is 2 mm. or more, no measurement is required; it appears always to be abnormal.

## Summary

In a large number of patients with chest or arm pain, it has been demonstrated that the patient's history, though very valuable, will not afford more diagnostic accuracy than 70 to 90 per cent. A normal resting electrocardiogram does not exclude coronary artery disease. Standardization of a functional test

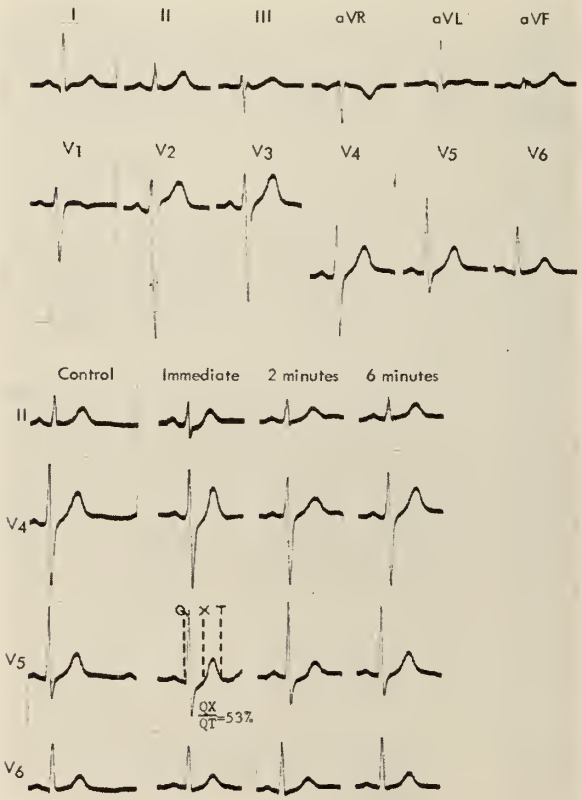



FIG. 7. *A 43 year old man with an anginal syndrome. The 12-lead resting electrocardiogram is normal. The postexercise electrocardiogram, the double (3 minute) "2-step" test reveals "j" or junctional RS-T depressions. The QX/QT fraction is prolonged to 53 per cent (see lead Immediate $V_5$).*

of the heart is, therefore, requisite. A *negative double "2-step"* test is extremely good evidence that heart disease is absent. *"Ischemic" RS-T segment* depression indicates "organic" heart disease 95 per cent of the time. More precise evaluation may be obtained by determinations of the QX/QT ratio and the QTc duration, particularly in regard to eliminating "false negative" interpretations. A QT ratio (calculated QT/expected QT for the same heart rate) of 1.08 or greater and a QX/QT ratio of 50 per cent or greater are considered abnormal.

The QX/QT fraction and/or the QT ratio must always be measured before concluding that a *"j" or "junctional"* depression is merely a functional change

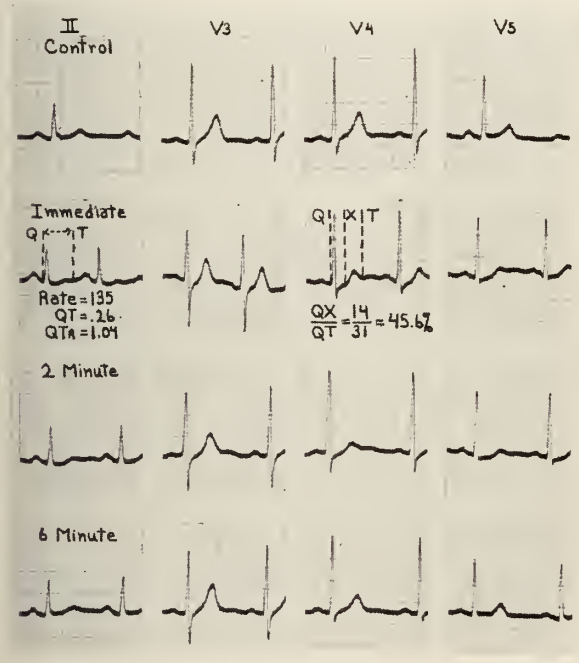



FIG. 8. *A 48 year old man with chest pressure noncardiac in origin. The 12-lead resting electrocardiogram is normal (only leads II, $V_{3,4,5}$ shown). RS-T depressions are of the "j" or junctional type (see lead Immediate $V_4$). The QX/QT fraction is 45.6 per cent, within normal limits. The QT ratio (see lead Immediate II) is also within normal range, 1.04.*

in the postexercise electrocardiogram, as junctional depressions may be indicative of organic disease when they are 2.0 mm. or more in depth or when they are associated with prolonged QX/QT ratios or abnormal QT intervals.

In conclusion the "2-step" test is *negative* (normal) if:

1. There is no change. (Visual inspection usually suffices, but the QT ratio which refines the interpretation, should also be measured when the pain suggests a cardiac origin.)
2. There is a "j" depression under 2 mm. and the QX/QT and QT ratios are normal.

The "2-step" test is *positive* when there is:

1. "Ischemic" ST depression.
2. "j" depression 2 mm. or more.
3. "j" depression of relatively long duration (QX/QT ratio 50 per cent or more) or associated with prolonged systole (QT ratio 1.08 or more).
4. Inverted "u" wave.
5. RS-T elevation, which is rare.
6. Left bundle branch block, intraventricular block, A-V block and supraventricular with ventricular tachycardia.
7. Deeply inverted T-waves or multiple premature beats are suspicious. Right bundle branch block and Wolfe-Parkinson-White syndrome are less significant.

In our opinion, a resting electrocardiogram should be taken twice a year in all persons over 20 years of age and if it is normal, a "2-step" exercise test should be done. This applies particularly to persons in strenuous, dangerous or responsible occupations, civilian or military, including physicians, since even severe coronary disease may be silent or present predominantly noncardiac symptoms.

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Coronary Symposium

# Cine-Coronary Arteriography

F. MASON SONES, JR., M.D.

DURING the past four years an effort has been made to develop a technique which would completely eliminate any doubt concerning the presence or absence of obstructive lesions in human coronary arteries. During the past two years this objective has largely been achieved by a technique known as "selective cine-coronary arteriography."

*The Author*

● Dr. Sones, Cleveland, is head, Pediatric Cardiology and Cardiac Laboratory, Cleveland Clinic Foundation.

## Method

Using local anesthesia, a special catheter, the tip of which has an external diameter of 1.6 mm, is inserted into the right brachial artery. The catheter tip is passed into the ascending aorta and down to the aortic valve immediately above the left ventricle. The special catheter tip is then directed into the openings of the coronary arteries immediately above the aortic valve. Small quantities, (3 to 6 cc.) of contrast substance may then be slowly injected directly into the arteries which provide the blood supply to the heart muscle. During the injections high speed x-ray motion pictures are made at rates of 50 to 60 frames per second with an electrically driven 35 mm. motion picture camera and a fluoroscopic image intensifier.

## Obstructive Lesions

By studying the motion pictures, it is possible to recognize areas of narrowing in human coronary arteries, which cause less than a 20 per cent reduction in the lumen diameters of major coronary artery trunks. Terminal branches of the vessels as small as 80 microns in diameter are usually seen, and mechanical obstructions which exceed 50 per cent of the internal diameter of the major arteries are easily demonstrated. It has thus become technically possible to make a "road map" of the coronary artery tree in the living human which may be used dependably to pinpoint the exact location and severity of mechanical obstructions to coronary artery blood flow. The method provides a more dependable objective basic standard for the recognition of such obstructions than has previously been available. It has been particularly helpful in ruling out the presence of such obstructions in patients with chest pain, in whom the diagnosis of coronary atherosclerosis could not be excluded by other diagnostic methods. It is expected that the application of cine-coronary arteriography will provide a more realistic basis for the evaluation of medical and surgical efforts to improve coronary artery blood flow.

## Collateral Channels

The most important known method by which the heart muscle is protected from the effects of occlusion of major coronary arteries is the opening up or development of new arterial channels known as "intercoronary collaterals." These small arterial channels, which have not been seen in any patient with normal coronary arteries, make their appearance and are directed into areas where the primary source of coronary artery blood has been partially or completely blocked. When these channels exist and have a lumen diameter larger than approximately 80 microns, they may be demonstrated by cine-coronary arteriography. In some patients, no such channels are demonstrable one to three years after complete occlusion of a major coronary artery trunk. In others, such channels have been demonstrated between the second and fourth weeks after acute coronary occlusion. In others with slowly developing mechanical obstructions, intercoronary collateral vessels have been demonstrated to be functioning effectively *before* complete occlusion of the primary source of blood flow to the involved area of heart muscle has occurred. Occasionally, these new arteries are seen to arise immediately above a major arterial obstruction, to pass directly around the obstructed area to fill, and to maintain patency of its distal radicals. In other instances, they arise from the most terminal branches of a normal or relatively normal vessel and provide a reversed type of blood flow into the terminal branches of another vessel whose proximal length is either completely or partially obstructed.

The location and size of these vessels varies infinitely in different patients with similar clinical manifestations of disease. Demonstration of their presence and relative efficiency in addition to demonstration of the locations and severity of obstructions in

Presented before The Cleveland Area Heart Society Eleventh Annual Meeting, November 30, 1960, Cleveland, Ohio.

the primary coronary artery trunks, should provide a more realistic basis for evaluating the individual patient's chance for survival and for applying specific forms of treatment than has heretofore been available to us.

### Clinical Application

Ultimately, it is hoped that the clinical application of this method will be used to eliminate the often disabling fear of coronary artery disease in patients in whom its possible existence cannot be excluded by other diagnostic methods and that it will make possible the development and application of better and more specific forms of treatment for those actually suffering from the disease.

The method has now been applied to the study of more than 500 patients. There were two fatalities in the total group of patients who represented the entire spectrum of coronary artery disease from those in whom coronary atherosclerosis was suspected but proven not to exist to patients with complete occlusion of two of the three major vessels, including several with acute myocardial infarction. Both deaths occurred in patients with severe valvular heart disease, more than 25 per cent cardiac enlargement and prolonged symptoms of heart failure. The risk on the basis of this experience in practical application is approximately equivalent to that involved in cardiac catheterization when it is used for the diagnosis of congenital malformations of the heart.

### ADDENDUM

In the interval from November, 1960, to July, 1962, more than 800 additional patients have been studied by the technique of cine-coronary arteriography. One additional death occurred in this series of patients. Current mortality experience incident to cine-coronary arteriography has been 0.23 per cent.

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**Coronary Symposium**

# Medical Therapy of the Chronic Coronary Patient

WILLIAM DOCK, M.D.

THE data on thrombo-embolic lesions and myocardial infarction in matched bodies of Negroes over 40 in Uganda and in St. Louis, Missouri,[1] show clearly that 90 per cent of thrombo-embolic disease and 97 per cent of coronary disease in St. Louis would have been prevented if the people had lived and worked like Ugandans. This confirms Snapper's observations on thrombo-embolic disease in China as compared with Holland, and Dedichen's data on the parallel fall of thrombo-embolic and coronary disease in Oslo during German occupation, and prompt parallel use when the usual Norwegian diet was restored. Africans are not unstressed, nor were Norwegians when Nazis invaded their city. The main factor in all the studies of high and low incidence of these diseases is diet.

Coronary infiltration sets in rapidly during infancy, in men and rabbits. It slows after humans drink less milk and is reabsorbed when rabbits are weaned onto a vegetable diet. In white men and in colored men and women coronary infiltration reaches a second peak during puberty and early adult life. In white women, it rises slowly after the third decade. Androgens alter lipo protein patterns and adolescent white men eat far more animal fat than their sisters.[2]

Presented before The Cleveland Area Heart Society Eleventh Annual Meeting, November 30, 1960, Cleveland, Ohio.

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### Lipids, Atheroma, and Clotting

Even those people whose blood lipids are highest (familial hyperlipemia or hypercholesterolemic diabetics) show a striking fall in all fractions on diets low in animal fat and free of alcohol, but with no decrease in calories as vegetable oil is substituted for animal fat (especially egg yolk and butter fat). Such people are sensitive to alcohol, egg phospholipid, or milk[3] and all of us have very marked rise in all our plasma lipids if we get dead drunk.[4] All of us, on ordinary diets, show a fall in all lipid levels

if we eat 3-6 grams of nicotinic acid or 4-8 mg. of D-thyroxin a day. These are agents with maximal effect, minimal side-effects. Triparanol lowers cholesterol but not other lipids. High triglyceride levels, apparently very important in impairing oxygen transport,[5] accelerating coagulation and retarding fibrinolysin, are more damaging than high cholesterol levels in the older, coronary and angina prone population.

Aside from diet and alcohol, stress and nicotine are important in accelerating coronary obstruction. At any level of bad diet, stress acts to raise plasma lipids, and in people with latent coronary disease, smoking upsets cardiac function, as shown by the ballistocardiograph[6] and by statistics of the American Cancer Society.[7]

For the person with latent coronary disease, a proper diet, minimal use of alcohol and tobacco, and plenty of quiet steady exercise, as recommended by William Osler in 1896, seems the part of wisdom. The value of anticoagulant is largely in relieving stress by assuring patients that their disease will not progress. Careful control studies in England and Norway, show no real protection in women or in men over 60, and minimal effect in acute coronary disease of either heparin or "coumarol" analogs. Yet heparin may have slight value in clearing hyperlipemia and preventing clot extension in patients at onset of an episode of angina, status anginosa, or myocardial infarction[8]: Among 41 patients heparinized after myocardial infarction (19 with angina, 9 with old infarcts, 8 with congestive failure) there were 9 deaths; among 40 controls of average age 3 years younger (15 with angina, 5 with old infarcts, 5 with congestive failure) there were 11 deaths.

## Bed Rest or Confinement To Quarters?

The trouble with ordering complete bed rest is that it greatly increases fright and stress in the patient. Reassurance, supported by any regime believed to be effective (diet, drugs) does wonders to allay fear and begin rehabilitation. It apparently does lower the death rate in cases of myocardial infarction to permit rest in chair and even strolling slowly, rather than immobilizing in bed for six weeks. This treatment is accepted by doctors even though some hesitate to use it on patients for fear of recriminations among those who may die. It is important to resume anything more than strolling short distances on the level very gradually and starting only after three to four weeks of confinement to quarters. By three months, however, all those with normal heart size and no angina or heart failure should be back leading normal lives. The problem of low fat and high intake of vegetable oil has been fully described by Page[9] and this is the one form of altered way of life most likely to meet the Hippocratic criteria of being harmless and physiological.

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DRUGS AND ANGINA PECTORIS.—Pharmacologically, angina pectoris may be relieved by measures that improve coronary blood flow, diminish cardiac effort, or affect pain transmission and reception. It is unfortunate that there is no good correlation between pharmacodynamics and clinical efficacy of many agents prescribed for treatment of angina pectoris. This is due to the fact that (1) drugs may act differently in different species and in normal hearts as opposed to diseased hearts; (2) drugs may have multiple sites of action, some of which are not yet recognized; and (3) the true mechanism of anginal pain has not been sufficiently defined to permit unqualified interpretation of the effect of any given drug.—ABSTRACT: Richard Gorlin, M. D., Boston: American Journal of Cardiology, 9:419-424, (March) 1962.

Coronary Symposium

# Lesions of the Coronary Arteries Of Surgical Interest

SYLVESTER E. GOULD, M. D.

WHEN I was a medical student, we were told that we didn't need to concern ourselves about trying to make an exact anatomic diagnosis in most instances of congenital heart disease since we couldn't do much about the lesion. Since that time great advances have been made in the diagnosis and surgical treatment of congenital heart disease, particularly since physiologists, cardiologists and surgeons have combined their talents to write what seems to me to be one of the exciting chapters in heart disease. It is encouraging to see at the present time similar teams of medical workers combining their efforts in the study and understanding of disease of the coronary arteries. I should like to present several lesions of the coronary arteries which may possibly be corrected by surgical means.

## Vascular Lesions

Atherosclerosis is today the scourge of mankind in many of the leading countries of the world. The lesion consists essentially of the association of atheromatous material and of fibrosis beneath the intima of arteries. Occlusion of a coronary artery or one of the main branches near its origin is the common cause of myocardial infarction.

Atherosclerotic coronary arteries are particularly susceptible to the development of a thrombus on an ulcerated plaque, causing occlusion with ensuing myocardial infarction. More frequently, the lumen is occluded by a hematoma which originates in an organizing atherosclerotic plaque in the subintimal layer of a coronary artery as the result of capillary hemorrhage. But perhaps most occlusions of the coronary arteries are caused by reduction or obliteration of the lumen by an enlarging atherosclerotic lesion. In some instances the occluding sclerotic lesion may represent the organized stage of a preceding hematoma, and yet it may be impossible to determine if this sequence of lesions has actually taken place.

Occasionally an atherosclerotic plaque occludes the ostium of a main coronary artery, or a primary or secondary neoplasm in the mediastinum causes external compression of a coronary artery. These conditions also may be diagnosed and may be correctable by surgical means.

With the development of coronary arteriography it seems likely that in the near future the surgeon will have a practical means for localizing coronary occlusions and an opportunity to resect or correct some of them. Frequently focal narrowing may be seen of the right coronary artery or of the anterior descending branch of the left artery near its origin. In such occlusions, the surgeon may well be able to cannulate and dilate the lumen to reestablish the continuity of the vessel. Or it may be possible to resect a narrowed or occluded section and replace it by a segment of arterial or plastic tubing.

Severe atherosclerosis of the coronary arteries does not always lead to total or partial occlusion, since the arteries may have dilatation of the lumen as a result of aging. While atherosclerosis is often associated with aging, it is not necessarily dependent upon it. Aging may often be a conditioning factor for atherosclerosis, but we frequently see atherosclerosis without evidence of aging and, occasionally, evidence of arterial aging without atherosclerosis. Perhaps surgeons might be able to produce some mechanical change within the aorta, possibly by partial coarctation, to increase the pressure in the coronary arteries and thereby induce dilatation of the coronary arteries.

Two other conditions may be mentioned which may possibly be helped by surgical means. In patients with angina caused by narrowing of the ostia and the very first portion of the coronary arteries by productive syphilitic subintimal fibrosis (endarteritis),


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the prognosis for life is usually worse than in patients with angina caused by atherosclerosis. In this type of obstruction a prosthetic cannula might be inserted into the first portion of the coronary arteries with beneficial results.

Finally, in polyarteritis nodosa it may be possible to diagnose involvement of a coronary artery and arteriography may provide additional help in localization of an occluding lesion. These patients are usually treated by steroids, which may delay the process with subsequent healing. The lumen of the vessel, however, often becomes occluded by thrombosis or obliterating fibrosis. As in the case of atherosclerosis of the coronary arteries, the affected segment or segments of an occluded vessel of large caliber might be removed and replaced by arterial or prosthetic tubing.

### Myocardial Lesions

In most reported series of autopsies with acute infarction, the incidence of rupture of an apical infarct is about 8 to 10 per cent. In cases of rupture reported up to the present time, it is often stated that there were no premonitory symptoms. It may be significant that rupture is usually delayed for some days after the onset of infarction. Although rupture may occur as early as the first day, it usually takes place between the 4th and 11th days, but may be delayed for as long as three weeks. What is the reason for the delay? It must be that there is softening of the infarcted muscle or spreading of the area of necrosis or hemorrhage. Ordinarily the rupture does not have the shape of a "blowout" or hole, but rather is a linear tear, 1 or 2 centimeters in length, which is the result of dissection of the infarcted muscle. Factors that may be associated with rupture include hypertension persisting after the infarction, sudden or fairly strenuous effort, and use of anticoagulants.

In several series that have been studied, the incidence of rupture has been about twice as great among patients receiving an anticoagulant as among those not receiving such a drug. We need to know more about the mechanism of rupture, what produces it after a delay of days or weeks following infarction, and how it can be prevented. Perhaps careful study of patients for early clues of the onset of this complication may enable us to make the diagnosis of beginning rupture in time to permit surgical intervention and save some of these patients.

Occasionally there is perforation of the interventricular septum following acute infarction. This condition can be diagnosed and in some instances the patient may be a candidate for surgical repair of the perforation and thus avoid progressive heart failure.

Another complication of infarction is ventricular aneurysm which occurs in about 8 per cent of infarcted hearts seen at necropsy. The aneurysmal sac may contain a laminated thrombus, sometimes massive in size. In some instances the laminated thrombus nearly fills the cavity of the left ventricle so that the patient has no chance to recover. If the presence of mural thrombus in a ventricular aneurysm can be diagnosed in time by ventriculography, corrective surgery might be indicated.

Several years ago we reviewed 5,000 consecutive necropsies and found one or more infarcts in 11.7 per cent, an incidence much higher than any other reported series. Of the persons with infarcts, the average age was 68 years; less than one fourth had recent infarcts and over three fourths had old infarcts; and in 30 per cent the condition was entirely unsuspected. The high incidence of unsuspected infarcts seems to me to be significant in that it represents a favorable aspect of myocardial infarction. At necropsy it is sometimes astonishing to see as much as 50 per cent of the substance of the left ventricle destroyed by infarction and replaced by scar tissue. Occasionally in such cases there is no history or suspicion of heart disease.

A frequent finding at necropsy is the association of a fresh apical infarct with an old posterior infarct or of a fresh posterior infarct with an old apical infarct. The reason is that atherosclerotic disease involves both coronary arteries simultaneously to a variable degree, is usually progressive, and both vessels may become occluded at different times.

Not stressed sufficiently but frequently encountered at necropsy is fresh patchy infarction which is superimposed upon old patchy fibrosis of the left ventricle. This indicates that a person with an old or recent infarct may be subject to recurrent damage at the same site, whether by insufficiency of the arterial supply to the area or as the result of progressive or recurrent occlusion of the vessel.

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ANTICOAGULANT THERAPY OF CEREBROVASCULAR DISEASE seems most efficacious in treating recurrent transient ischemic attacks and the slowly progressive stroke. Its value in the acute phase of cerebral thrombosis and in long-term postinfarction therapy is not yet clear. Its role in cerebral embolism seems to be well established; the authors usually withhold anticoagulants for 24 to 36 hours after an acute cerebral embolus and do not administer anticoagulants in the presence of a xanthochromic cerebral spinal fluid. They also believe that it is dangerous to use anticoagulants in the presence of severe hypertension.—ABSTRACT: S. N. Groch et al.: *Circulation,* 23:458-465 (March) 1961.

# The Clinical Evaluation of the Heart

## 1. The Anonymous Revolution

DANIEL K. BLOOMFIELD, M. D.*

BEFORE the days of the cardiac catheter, clinical cardiology was an art practiced by a skilled few whose vast experience led to diagnosis with impressive regularity. Less impressive was the ability of these men to communicate the bases for diagnosis to the casual physician, who so frequently had to settle for the "apical systolic murmur" type of description which meant so little to him. Angry reaction to that era is evident by the fervor with which medicine embraced the catheter, x-ray, electrocardiogram, phonocardiogram, angiocardiogram, and other mechanical techniques for diagnosis at the expense of clinical acumen. The doctor at last was emancipated from the stethoscope by the industrial revolution. So strong was this feeling that a noted Boston physician encased his stethoscope in glass as a memento to the ancient past.

But where did all this leave the practitioner in the average Ohio town? Since 1945 his instruction in clinical cardiology has been dominated largely by persons who "knew the only real way to diagnose heart disease is to catheterize." Training may have been restricted to modest murmur labeling, "$A_2$ greater than $P_2$," and other platitudes of cardiac nondescription that can be found in our most sophisticated journals even today. Without the sound background in clinical cardiology that should be as a birthright to every physician, he stands stunned by the startling progress made in cardiac evaluation by machine. He feels overwhelmed by the apparent complexity so that he descends to the middleman's spot between patient and robot-like superspecialist.

This need not be the case, and it is the purpose of this article and those that follow to point this out, for it is a basic fact that *the clinical evaluation of the cardiac patient is the most powerful single diagnostic tool available today.* The statement covers the old and the young, the congenital and the acquired, and the pink and the blue. Furthermore, the basis for this skill, which is available to every physician, is the methodical and logical examination of the patient. The advances in clinical evaluation, and particularly auscultation, have been achieved through the efforts of many workers by painstaking correlation of clinical, phonocardiographic, physiological, surgical, and pathological data. What has emerged today, unheralded and virtually unknown, is a powerful methodology for cardiovascular examination which can be used by general practitioner and specialist alike. It is as simple and logical as it is elegant. Perhaps a few examples will illustrate these arguments.

Case 1: A 10 year old boy who presented with a modest aortic ejection murmur, normal x-ray, and normal electrocardiogram, was sent for evaluation of possible aortic stenosis. The most striking feature of his physical examination was the very simple observation of a paradoxical split of his second sound at the base, pathognomonic of severe stenosis in such a case.

Case 2: A case of rheumatic aortic valve disease in a 40 year old man, presented as a problem in estimation of aortic regurgitation versus aortic stenosis. The diagnosis was made from the foot of the bed simply by looking at the patient's neck and noting carotid pulstations, which are never obvious with dominant aortic stenosis.

Case 3: A 20 year old man being treated for acute rheumatic fever, because of a murmur, fever, elevated erythrocyte sedimentation rate, and antistreptolysin O titer was observed to have the murmur of tricuspid insufficiency. This was a most unusual clinical finding and led to the correct suggestion of a right atrial myxoma.

In each of the three cases a definitive conclusion was arrived at by methods that a physician should find simple, but more likely would miss. For that reason this article has been subtitled "The Anonymous Revolution" because the interpretation of sounds, murmurs, and physical signs which will be described in succeeding articles has been so very slow in filtering through to physicians at large. This stems from the facts that (1) literature describing clinical advances in detail or in summary become tangled with clicks and splits that do not interest the nonspecialist; and (2) the intense bedside auscultatory discipline necessary for success must largely be self-taught and practiced with each patient. It is much like the game of bridge. The cards are known. The rules are known. Experts bare their skills for all to view. But, without intensive and continued practice, play is amateurish. The purpose of these articles which will appear on the "Heart Page" of this journal, will not be to make each physician a cardiologist, but to present him with a sound clinical basis of approach to the normal and abnormal heart.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT P. CARSON, M.D., *President*

### *Presented by*


- **Joseph M. Ryan, M.D., Columbus, and**
- **Emmerich von Haam, M.D., Columbus.**

**Edited by Dr. von Haam.**


PRESENTATION OF CASE

THIS 29 year old white woman had been in excellent health until seven weeks prior to her University Hospital admission, when she had the acute onset of a febrile illness with nonproductive cough. She was hospitalized elsewhere and a diagnosis of bilateral bronchopneumonia was made. She was treated for 10 days with Declomycin® but never became completely afebrile prior to discharge. She developed a "cold abscess" in the deltoid from intramuscular injections. This was incised and drained. Five weeks prior to her admission here she was readmitted to her local hospital with a temperature of 105° and diffuse bronchopneumonia. Sputum cultures were negative and blood cultures grew out a coagulase-positive staphylococcus which was resistant to penicillin. She was given Combiotic® for three days, Chloromycetin® for seven days, erythromycin for nine days and Vancomycin® for 13 days with transient reduction of fever only on the latter two drugs. Her temperature subsequently rose to 106-107°. Repeat chest x-ray was negative. She developed petechiae in the conjunctivae, and three days later she was transferred to University Hospital.

### Physical Examination

The patient was a moderately obese, acutely ill white woman with a blood pressure of 100/60, pulse rate of 140 per minute, and temperature of 105°. There were petechiae on both conjunctivae. The mucous membranes appeared pale. There was no lymphadenopathy. Coarse rales were present in the left base with diminished breath sounds over this area. The heart was not enlarged. There was a split first sound at the apex with a soft, blowing, grade 2 apical systolic murmur. No thrill was palpable. One observer thought he could hear a pericardial friction rub at the base of the heart. The tip of the spleen was felt at the left costal margin. Petechiae were noted in the pharynx. There was no peripheral edema.

### Laboratory Data

The hemoglobin on admission was 7.6 Gm.; the white blood cell count was 4,950 per cu. mm. with 87 per cent polymorphonuclear leukocytes, 5 per cent lymphocytes, 5 per cent monocytes, and 3 per cent metamyelocytes. The urine had a specific gravity of 1.024, an acid pH, 30 mg. of protein per 100 ml., 0-3 granular casts, 4-6 white blood cells, 6-10 red blood cells, and 2 plus bacteria. The blood urea nitrogen was 10 mg., the blood sugar 117 mg. per 100 ml. The van den Bergh was 0.2 mg. direct, 0.5 mg. per 100 ml. total. On admission the serum sodium was 144, potassium 3.9, chloride 99, and $CO_2$ combining power 27 mEq./L. Cultures from the nose and throat were negative. Blood cultures on the day of admission grew out a coagulase-positive staphylococcus which was reported resistant to penicillin but sensitive to all other antibiotics tested. An electrocardiogram showed sinus tachycardia with myocardial changes, which were thought secondary to the tachycardia.

### Hospital Course

The patient had temperatures of 101-102 with spikes to 104 and 105° over the 19 days of hospitalization. At no time was she completely free of fever. For the first six days she was given erythromycin, 1 Gm. every six hours, aqueous penicillin intravenously in the range of 80 million units per 24 hours, and Bacitracin,® 25,000 units intramuscularly every six hours. During the early part of hospitalization her physical findings remained essentially unchanged, and there was no change in the heart murmur. Her hemoglobin was kept around 12 Gm. by transfusions of whole blood. On the sixth hospital day she developed a rash in the intertriginous areas. The tachycardia persisted. She had a moderately distended abdomen. It was thought that she had a right upper lobe pneumonia, and chest x-ray, though

Submitted June 30, 1962.

technically poor, suggested right upper lobe infiltration. After six days, Chloromycetin 4 Gm. per day, and Spontin,® given intravenously in a total of 5 Gm. a day, were substituted for the previous therapy.

On the seventh hospital day the rash was present all over the body and the patient was mentally confused and hallucinating. On the tenth hospital day her left leg became swollen, tender, and somewhat reddened along the distribution of the saphenous vein. This was thought to be due to intravenous medication. Her abdomen remained moderately distended. There was no nausea or vomiting; her bowel sounds were always active. She continued to take small amounts of food, and oral fluid intake of 1500-2000 cc. was supplemented with 1500-2500 cc. of intravenous fluids each 24 hours. Her urine output remained good.

On the twelfth hospital day, her abdomen appeared less distended. Mentally she seemed somewhat clearer. The rash cleared by the fourteenth to fifteenth day. On her thirteenth hospital day her conjunctivae and nail beds were free of petechiae. In attempting to use the bedpan on the nineteenth hospital day she suddenly became apneic, took several deep breaths, then had what was described as a violent shaking spell and died.

## CLINICAL DISCUSSION

DR. RYAN: It seems to me that we are dealing here with a case of subacute bacterial endocarditis due to staphylococcus. The woman was sick about 10 weeks and repeated blood cultures grew out staphylococci which were coagulase-positive. It would seem to me very unusual if a patient were to have persistent bacteremia of this duration without having bacterial endocarditis. In addition she had a heart murmur, and she developed anemia. She had a relative leukopenia for this degree of infection, but that is very common in bacterial endocarditis. She had petechiae, and her urinalysis was also completely in keeping with our diagnosis.

This case points up the difficulty one has in treating bacterial endocarditis when penicillin is excluded by a resistant organism. It also gives us an opportunity to review some of our thoughts about endocarditis. Subacute bacterial endocarditis used to mean, and to many people still does mean, an infection of a heart valve previously afflicted by a rheumatic or congenital lesion. Furthermore, if the infection lasted six weeks or more this was considered subacute and anything less than that was acute.

To me, the most logical way to approach bacterial endocarditis in this era of antibiotics is to ask yourself: (1) What is the causative organism? and (2) Can you determine whether there was preëxisting heart disease or not? I believe we might well discard our old terms of subacute and acute bacterial endocarditis and call them what they are. Alpha hemolytic streptococcus infection on an aortic insufficiency due to rheumatic heart disease seems to me to make more sense than subacute bacterial endocarditis. Acute bacterial endocarditis meant to many of us that an organism got into the blood stream and attacked a normal heart valve. Hemolytic streptococci can do this, pneumococci can do this. Again, I think one wants to know what the etiologic agent is, and if there was preëxisting heart disease.

### Hospital-Acquired Staphylococcus

This woman went to her local hospital with pneumonia seven weeks before she came to our hospital. Was the portal of entry of the staphylococcus staphylococcic pneumonia or was there an additional portal of entry in a patient debilitated from pneumonia? I rather favor the latter. I think this was probably a hospital-acquired staphylococcus infection, and maybe this so-called "cold abscess" that she developed in her first hospital was a staphylococcus infection and the portal of entry which led to her bacterial endocarditis. If you come into a hospital with a staphylococcic endocarditis it is entirely different than if you come in with another illness and when your guards are down, so to speak, a staphylococcus sneaks in and you develop a hospital-acquired staphylococcic endocarditis. This, in our experience, has been a very disastrous situation, as it was in this woman.

It is interetsing how these staphylococci could become so resistant to our therapy. They just seem to "chew up" penicillin and spit it out. They also can develop a penicillinase and inactivate penicillin. We have seen a number of such cases following cardiac surgery. Here is a really sick patient who, in a few days to a week after surgery, suddenly develops an obvious staphylococcus infection. It is often somewhat difficult to recognize at first because all these patients have fever postoperatively and we are inclined to argue, "Well, they have hemothorax, they are debilitated, they are not ventillating their lungs well, and this is the usual course of events that an individual goes through postoperatively." Hemotologists see staphylococcus infections in leukemic patients when their guards are down, endocrinologists see it in diabetes, et cetera.

### Nature of Valvular Lesion

Now, what kind of a heart lesion did this woman have? There is described for us a grade 2 soft apical systolic murmur in an apparently normal sized heart. This really does not help us a great deal because we observed it seven weeks after the onset of her infection. Does this mean that she had rheumatic heart disease with mitral valvulitis and mild mitral regurgitation? It may well mean that. It seems to me that bacterial endocarditis localizes more frequently on mildly deformed valves than on severely deformed valves. I would suspect then that this patient might well have rheumatic heart disease with mild mitral insufficiency. Why do I not conclude that she had a normal heart and that the staphylococci destroyed the valve and that that is where the murmur

came from? I have a few reasons for this and we will soon see whether they are sound.

### Pre-existing Mitral Valvulitis

Her illness lasted almost 10 weeks. This murmur apparently did not change much, so, if this staphylococcus did cause acute valvular destruction, it stopped after a certain degree of deformity had been reached. She also had no evidence of progressive cardiac failure or progressive cardiac enlargement. This may mean that she had mild rheumatic valvulitis with mild mitral regurgitation before the valve became infected. I don't think a heart as a rule tolerates sudden acute changes in hemodynamics and sudden acute changes such as acute mitral regurgitation or acute aortic insufficiency. These people usually go into heart failure rather abruptly. Could she possibly have a right-sided endocarditis? This is quite common, especially in patients who have had a lot of intravenous therapy. It is very common in a hospital population where you have many morphine addicts. These people are not too careful about sterilization of their hypodermics and their needles. However, I think the murmur described for us came from the mitral valve, and statistical evidence would favor the mitral valve. The best figures we could find point out that staphylococci localize on the mitral valve three times as frequently as on the tricuspid valve.

She did have a lot of pulmonary complications, and this is rather frequent in a right-sided endocarditis. But it seems to me that the pulmonary lesion antedated rather than followed the onset of her endocarditis. We do not say that she started with a staphylococcus pneumonia, but we say that she started with a pneumonia and staphylococci are as notoriously prone to produce pneumonitis as they do bacterial endocarditis. Furthermore they may well produce small abscesses in the lung, and this also may be a site of metastatic lesions for staphylococcus infection. So I would not be surprised if we find pneumonia and evidence of small abscesses. Somebody heard a pericardial friction rub, and this would not be too rare, I think, in bacterial endocarditis, especially in somebody with pneumonia. We may well find evidence of an old healed pericarditis.

The skin rash is a little troublesome to explain. We do see skin rashes with bacterial endocarditis, but certainly this woman had all the antibiotics known to man up to that time, which are notoriously rash producers.

What about her nondescript abdominal symptoms? She had pain, some distention, but normal bowel sounds. Certainly I don't think we are going to find anything really troublesome in the abdomen. I think this is again a symptom in a patient who is quite ill with bacterial endocarditis. We may find evidence of small splenic infarcts.

What about the central nervous system? This woman had hallucinations and was confused. Central nervous system lesions are very common in bacterial endocarditis and are caused by either emboli or small abscesses, or patients with this amount of fever may become irrational. I rather doubt that we will find abscesses. She may have some small emboli.

### Bedpan Death

How did the patient die? As I read progress notes everybody seems to improve up until the last 24 hours and then suddenly dies. This woman died after trying to get on the bedpan. If you have ever used a bedpan you know that this is quite a strenuous maneuver and, in a sense, it is a modified Valsalva maneuver. At the onset of a Valsalva maneuver the strain causes an enormous reduction in cardiac output which may well cause a reduction in coronary flow. What did it mean in this woman? I would not be at all surprised if this patient had myocarditis in addition to her subacute bacterial endocarditis. This is very common in staphylococcus infection. Patients can have miliary myocardial abscesses and die a sudden death after the strain of using the bedpan.

Could she have had a coronary embolus? It is possible. I would like this much better if her lesion were on the aortic rather than the mitral valve. People with aortic valvulitis very commonly have coronary emboli and can develop all the symptoms of myocardial infarction. However, with the suddenness of her death after she became apneic and took several deep breaths, a sudden disturbance in heart rhythm should be postulated as the cause of death. The protocol indicates that she had thrombophlebitis. Did she dislodge a clot on getting on the bedpan and have a massive pulmonary embolus which was the cause of death? I rather doubt this but it is not impossible. Usually with pulmonary embolism the respiratory difficulties are much more severe and last longer. With the strain of using the bedpan she also could have ruptured a mycotic aneurysm and died of a massive cerebral hemorrhage. It would have to be an aneurysm located at a very vital center to kill her this quickly. I rather doubt this and I mention it only to reject it.

Therefore I would like to say that this woman had staphylococcic endocarditis with mitral valvulitis on a heart previously damaged from rheumatic fever, that she had myocarditis possibly with miliary abscesses, that she had evidence of healed pericarditis, that she had pneumonia, possibly some small pulmonary abscesses, and that she might well have had some focal glomerulitis in the kidneys as we often see with bacterial endocarditis. I would attribute her death to a sudden rhythm disturbance of her heart engendered by the strain incident to using the bedpan.

### Prognosis of Bacterial Endocarditis

The advent of antibiotics has reduced the mortality of bacterial endocarditis to about 50 per cent. As-

suming that we might have cured this woman's bacterial endocarditis, this does not mean she was going to be cured functionally. Many of these people go on to die of the consequences of their continuing insufficiency due to the destruction of the valves by the endocarditis. So bacteriological cure does not mean cure of the patient. I personally feel very uncertain about the therapy of bacterial endocarditis when these organisms are resistant to penicillin. We usually use penicillin, sometimes in astronomical doses of 150,000,000 units a day, in addition to all other antibiotics. The laboratory reports on the blood cultures come back, "Sensitive to penicillin" in certain dilutions. But this refers to a test performed with a disk impregnated with an antibiotic which inhibits growth. What we really want to know is, What is the bacteriocidal activity of this drug if given to this patient, and is this sufficient to kill the organism in question? You have heard, I am sure, Dr. Saslaw emphasize over and over again that with bacterial endocarditis one is looking for a bacteriocidal drug, not a bacteriostatic drug. Bacteriostatic drugs are something like the opponents of the Fifth Amendment: they just drive the staphylococcus underground and we forget about them, and as soon as we stop the drug the organisms reassert themselves.

### CLINICAL DIAGNOSIS

1. Staphylococcal endocarditis of mitral valve.
2. Mild rheumatic heart disease with mitral insufficiency.
3. Healed pericarditis.
4. Pneumonia with abscess formation.
5. Possible emboli to spleen, kidney and brain.

### PATHOLOGICAL DIAGNOSIS

1. Staphylococcal endocarditis of mitral valve.
2. Inactive rheumatic heart disease with mitral insufficiency and pancarditis.
3. Organizing bronchopneumonia.
4. Embolic infarcts in spleen and kidneys.

### PATHOLOGICAL DISCUSSION

DR. VON HAAM: At autopsy we found her heart not much enlarged. The aortic leaflet of the mitral valve was diffusely thickened and the chordae tendineae appeared slightly thickened and fibrotic. The edges and the auricular surface of the mitral valve were occupied by a soft gray granular vegetation. The lungs were heavy and mottled and showed patchy dark-red nodular areas. The spleen weighed 650 Gm. and showed four pale yellow infarcts. The liver was slightly enlarged and had the nutmeg appearance of chronic congestion. The kidneys also showed small yellowish white infarcts but appeared otherwise normal. Permission for examination of the head was not granted.

The microscopic section of the mitral valve showed a vegetation composed of fibrinoid eosinophilic material with numerous bacterial colonies. The base of the mitral valve showed a marked deposition of collagen with some vascularization of the valve suggestive of an inactive mitral valvulitis. Section of the myocardium showed a perivascular fibrosis with an occasional Aschoff body of the proliferative type. The pericardium showed a hemorrhagic pericarditis. Section through the lungs showed evidence of recent hemorrhages and focal areas of organizing pneumonitis with incipient interstitial fibrosis. The spleen showed septic endarteritis with thrombosis and formation of bland infarcts. The same type of lesion was noticed in the kidney. In addition some of the glomeruli showed septic emboli typical of embolic glomerulonephritis. The bone marrow showed diffuse myeloid hyperplasia, and the skin rash failed to show the bacterial colonies of impetigo and was probably caused by toxins.

In conclusion, I feel that the patient suffered from staphylococcal endocarditis superimposed on a symptomless and probably inactive rheumatic heart disease. Due to the partially effective treatment, the character of this bacterial endocarditis changed and now resembled in some respects that of subacute bacterial endocarditis. For this reason I fully agree with Dr. Ryan that the clinical as well as the pathological differentiation of these two forms of endocarditis will probably become more and more difficult and rather purposeless.

I am of the opinion that the rheumatic involvement of her heart was rather mild and, by the time she developed her bacterial endocarditis, was probably inactive. We know from experience that bacterial vegetations prefer valves which are less deformed by previous rheumatic disease. The presence of Aschoff bodies in the heart does not necessarily speak for activity of her rheumatic infection since they also can be observed in patients with prolonged valvular disease and without evidence of active rheumatic fever. I do not think that this preceding rheumatic fever contributed anything to her death, although I cannot absolutely disprove Dr. Ryan's contention that her death was due to electric changes in her heart rhythm initiated by some type of myocarditis. We certainly did not find any myocardial abscesses or anything resembling coronary embolism.

With regard to the portal of entry of her staphylococcal infection, I again agree with Dr. Ryan and consider it a hospital-acquired infection rather than an infection introduced by her pneumonic process. The latter, although still active, was definitely in an early stage of granulation tissue and suggested a viral rather than a bacterial etiology. The infarcts in the spleen and liver were exactly of the type Dr. Ryan predicted.

# Maternal Deaths Involving Sepsis

## With Comment of Consulting Obstetrician and Gynecologist

By the OSMA COMMITTEE ON MATERNAL HEALTH

SEPSIS, or infection, associated with the pregnant state may cause maternal deaths in various ways through devious routes. The bizarre diversity of these pathologic processes in comparison to the older "Semmelweis Sepsis" provokes intrigue in members of the Committee as they study and evaluate maternal cases. Herewith the Committee presents three cases of maternal death involving infection, one postabortal, one postcesarean section, and one of a patient who died undelivered. While one case typifies a fulminating septicemia, the other two demonstrate peritonitis with a fatal termination. In two the etiological organism was *E. Coli;* in the other a *Staphylococcus albus* was isolated.

### Case No. 401

This patient was a 37 year old Negro woman, abortus V, (1= twins), who died one day postabortal. In her past history there was no organic disease, but she was said to have had "neurotic gastritis." Four previous pregnancies (one was multiple) terminated in spontaneous abortions, ranging from 6 to 22 weeks. These were attributed to "cervical insufficiency"; all four were completed by dilatation and curettment. A "cesarean section" (hysterotomy) was performed in 1955 for the 22 week gestation. This also was followed later by a dilatation and curettage. With her last menstrual period November 25, she registered for her fifth pregnancy soon after the first missed period, January 18. Bed rest, progesterone and Hesper-C were prescribed because of the past obstetrical history. However, two episodes of spotting and cramping occurred, February 12 and March 15, but these apparently responded to increased dosages of medication.

In order to maintain the patient at bed rest, periodic visits were made by the physician to her home. On May 13 the patient's amnion began to leak; she was hospitalized at once (24 weeks) and treated with 600,000 units of penicillin, and phenobarbital gr. 1½ daily. A week later (May 20) the patient experienced a chill, temperature 105°, pulse rate 92 per minute, and blood pressure 110/70. Cultures were run on both urine and blood. Therapy was reinforced with large doses of Terramycin® and Achromycin®, in addition to parenteral fluids. At 11:00 a. m., May 21, labor began spontaneously. After two hours and 40 minutes a macerated fetus was delivered, frank breech, assisted. The placenta, temporarily arrested in the cervical os, was easily delivered with the aid of ring forceps. Blood loss was estimated at 75 cc. Ergotrate® and Pitocin® were administered, while the antibiotics were continued.

The next day (May 22) at 3:30 a. m. the patient suddenly went into shock, with subnormal temperature and blood pressure 70/50. It was observed the patient had excreted only 8 cc. of urine since delivery. Parenteral fluids were stopped, and therapy consisted of Wyamine®, one unit of blood, and nasal oxygen. An hour later the indwelling catheter produced a total of 15 cc. of bloody urine; the blood pressure was 100/50. Blood was secured in preparation for the artificial kidney, but at 5:00 p. m. the patient became progressively worse, and died three hours later, in spite of therapy. Blood culture revealed presence of *E. Coli.* An autopsy was done.

*Pathological Diagnosis:* Fulminating septicemia (culture *E. Coli)*; marked acute endometritis with thrombosis of endometrial sinuses; acute nephrosis; recent infarcts lower lobes lungs (bilateral); bilateral bronchopneumonia, marked pulmonary edema: petechial hemorrhage pericardium and epicardium; acute splenitis.

### Comment

The Committee studied details in this case carefully, noting with appreciation the facts submitted. Members could only speculate as to the source of the infection, which was obviously an ascending one. The time of its inoculation was considered as conjecture. Two members suggested that a cervical culture and sensitivity taken on May 13 might have furnished a basis for *accurate* therapy before the chills and fever developed May 22. Likewise, members felt a cervical culture immediately after delivery would have helped. After prolonged discussion, the Committee voted this a nonpreventable maternal death; unavoidable catastrophe.

### Case No. 404

This patient was a 25 year old, white, primigravida, who died 12 days postpartum (postcesarean section). The past history was not remarkable. She registered with her physician in the third month and made 10 visits; prenatal care appeared adequate, with weight gain of 8 pounds. Her last menstrual period was July 15 (due date April 22). Physical examination noted a heavy woman, "short squatty" stature, with an android type pelvis. On April 11, x-ray pelvimetry reported that the volume of the fetal skull exceeded that of mid-pelvis by 290 cc. The patient ruptured her membranes (?), and two days later (April 29) labor began spontaneously, following which she was admitted to the hospital. She received Demerol® and scopolamine at 7:00 a. m. Three hours later, after regular contractions, the cervix was "2½ fingers," fetal head at minus 2 station. Consultation was obtained.

For cephalopelvic disproportion, a low cervical cesarean section was done at 10:30 a. m., delivering a 6 lb. 2 oz. living baby; the anesthesia (cyclopropane and curare) was given by a physician. At operation the fetal head was in left occiput posterior position; amniotic fluid was thick and abundant in meconium. On May 1 (48 hours postoperative) emesis and paralytic ileus developed. A Levin tube

A continuous state wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here in March, June, September, and December, interspersed with statistical summaries.

was inserted. The patient's temperature rose to 100° on May 2; parenteral fluids were administered; hot applications were placed on the abdomen. The following day her temperature was 102.4°, the lochia was foul; Chloromycetin® was administered (dosage not given). X-rays showed dilated loops of colon. Surgical consultation was obtained; conservative management was advised.

On the sixth day (May 5), the lower pole of the abdominal incision opened, drainage appeared, and, after culture, *E. Coli* was isolated, sensitive to Chloromycetin. Purulent drainage from the incision was followed by general improvement. Bowel sounds returned and the patient had several loose stools. The Levin tube was removed, following which oral feedings were begun. On May 9 (tenth postoperative day) abdominal distention reappeared, and dehiscense was feared. The patient was returned to surgery for an exploratory laparotomy. Generalized purulent peritonitis was present, with subphrenic and subhepatic abscesses; these were drained; loops of adherent intestines were freed. The uterine wound was healed. On closure, the abdomen was drained with a Penrose drain. The next day the patient's temperature soared. Oxygen, digitalis and a transfusion comprised treatment. Then, in spite of therapy, the patient's temperature elevated to 106°, shock developed, and she died May 11. There was no autopsy.

*Cause of Death (Certificate):* Pregnancy at term, delivered; *E. Coli* peritonitis, wound infection, secondary intestinal obstruction, intra-abdominal abscesses; shock and toxemia, overwhelming sepsis.

### Comment

The Committee, after carefully studying the abundant details in the case, voted this a preventable maternal death. Members discussed many avoidable factors, principally resolving them into several, e. g.: it was felt the initial operation (cesarean) was performed too late, in view of the preliminary x-ray report. Laboratory reports (leukocytosis) were not reported prior to the first surgery — possibly a break in technic initiated entrance of the organism. Finally, supportive therapy seemed scant; members agreed the patient was in poor condition for the second operation.

## Case No. 408

This patient was a 26 year old, white, primigravida, who died undelivered in her twentieth week of gestation. The past history revealed an appendectomy in 1947, followed by jaundice later the same year. Several years later there was a laparotomy for "lysis of adhesions." With a last menstrual period January 1, the patient apparently had a normal course until April 16 (15 weeks), when she developed epigastric pain, nausea and vomiting. On April 19 she was admitted to the hospital. Laboratory studies revealed four plus proteinuria, leukocytosis 13,900 with 85 per cent polymorphonuclears. Abdominal rigidity was marked. Electrolytes and Tetrex® were administered, followed by improvement in patient's condition. She was discharged April 28, with a diagnosis of "hyperemesis and ketosis." On May 1, the patient was readmitted with the same complaints, e. g., epigastric pain and vomiting, but there was no abdominal tenderness. Abdominal distention became progressive; the pain persisted. Temperature and pulse rate began to rise May 6.

Joint consultation (medical, obstetrical, surgical) was obtained; the final decision was to *not* operate, due to generally poor condition of the patient, i. e., dehydration, and electrolyte imbalance. However, the decision was changed May 8, and a laparotomy was performed at 7:00 p. m. Found: 1,600 cc. of free fluid in the peritoneal cavity, three ileal perforations, and almost complete severance of the ileum at one spot, due to bands of adhesions. The operation included lysis of adhesions, ileostomy, suture of the perforations and drainage. At 9:00 a. m. on May 9 the pulse rate rose to 180 per minute, and pulmonary atelectasis developed. At 9:16 a. m. the patient became apneic and cyanotic, with a pulse rate of 145 per minute. Cardiac arrest developed suddenly; cardiac massage was of no avail. The patient died at 9:58 a. m., 14 hours following laparotomy. Autopsy was permitted.

*Pathological Diagnosis:* Myocarditis; cardiac arrest; complete atelectasis, left lung, partial of right lung; multiple perforations of the small bowel; generalized peritonitis; septicemia *(Staphylococcus albus);* pregnancy, uterine three and one-half months, in situ.

### Comment

With a sense of astonishment the Committee carefully reviewed the available data in this case. Members regretted the omission of daily details, including temperatures, urine examinations, blood cultures, x-ray examinations, etc. It seemed that the source of the infection focused upon the gastrointestinal tract, — this then had no direct connection with the undisturbed pregnancy. However, certain members agreed that presence of the pregnancy masked the symptoms, thereby resulting in an obvious *delay* in the final laparotomy. By a narrow vote, the Committee voted this a preventable maternal death.

### Comment of Consultant

The following comment of a consultant, who is a specialist in obstetrics and gynecology, was furnished at the request of the Committee:

"Case No. 401: This is a typical case of Septic Obstetrical Shock with the development of sudden unexplained shock following delivery along with chills and fever. The problem of septic shock must be considered when one finds that the obstetrical patient under treatment for hemorrhagic shock does not respond to blood replacement. Anuria which occurred in this case is a frequent complication of septic shock. One can doubt the value of an artificial kidney, the use of which had been planned. It is of value only when blood potassium levels rise and cardiac toxicity develops. This usually does not occur for a week or 10 days. In such an *acute* condition, one is dealing with an unknown organism. In case of doubt, massive doses of antibiotics is probably a safer procedure than waiting for a definite diagnosis. If a patient with severe septic shock does not respond to massive antibiotics, blood and an intravenous infusion of vasopressors, the only hope for survival is an immediate hysterectomy. Even in a state of shock, patients will survive such an operation and have a successful recovery.

"Case No. 404: This appears to be an example of Puerperal Sepsis which possibly could have been avoided if cervical cultures had been taken at the time of ruptured membranes two days before onset of spontaneous labor; massive specific antiobiotics would have been available when sepsis first appeared. One is unable, from the available history, to determine whether or not too long a trial of labor had been used *before* the cesarean section was performed. Since details are not available, one wonders whether or not the Ochsner-Scherren conservative therapy for peritonitis would have been preferable to the explora-

tory laparotomy which was done in this case on the tenth postoperative day.

Case No. 408: This is a most difficult case to evaluate, since the pregnancy *did* mask the mechanical bowel obstruction due to adhesions. X-ray studies in the nonpregnant patient would have made the diagnosis of mechanical bowel obstruction ever so much more simple. Apparently no x-ray studies were done in this three and a half month pregnancy because of possible immediate harm to the fetus along with possible genetic damage to future generations. I am inclined to disagree with the Committee; in view of the information available, it's my belief that this is a nonpreventable maternal death."

* * *

*With this issue of* THE JOURNAL, *the "Maternal Health in Ohio" column completes six years of continuous publication on a monthly basis. The Committee on Maternal Health is to be congratulated on the excellent work it has done! Due to an increasing lack of space, this column hereafter will appear only on a quarterly basis in the issues of March, June, September and December of* THE JOURNAL. *This measure is inaugurated with regret, but with the unending cooperation of the Committee.*—ED.

## Treatment of Habitual Aborters By Psychotherapy

From their own observations and from evidence in studies by other investigators, the authors concluded that, for the most part, women who abort fall into two personality groups: (1) the basically immature, who cannot accept the outstanding responsibility of becoming a mother, and (2) the independent and frustrated, who have been conditioned to and yearn for the rewards of the male world and feel that maternity is less satisfying, if not unsatisfying.

Their study to test the value of psychotherapy in such patients included two groups of 19 pregnant women each; all 38 had previously aborted at least three times. One group, which served as controls, received no supportive psychotherapy but did have routine prenatal care by their family physicians. The other group received psychotherapy at regular intervals and on their occasional request; no hormone preparations were used, but occasionally a prescription for small doses of phenobarbital or meprobamate was permitted. There were only two abortions and one premature delivery in the group given psychotherapy; in contrast, there were 13 abortions and one premature delivery in the group given routine prenatal care.—ABSTRACT: Carl Tupper, and R. J. Weil, Halifax, N. S.: *American Journal of Obstetrics and Gynecology,* 83:421-424 (February 15) 1962.

## Franklin County Pelvic Cancer Delay Committee Report

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee at its May 16, 1962 meeting.

Case No. 101: A 48 year old white woman, gravida V, Para V, was admitted to University Hospital on November 18, with a history of irregular vaginal bleeding of one year duration. She stated that her last normal menstrual period was four years ago. Over the past six weeks she had noted an increasing mass in her lower abdomen which was not associated with any pain or discomfort. In addition to irregular vaginal bleeding, equally distressing to the patient was a 20 pound unexplained weight loss during the past year.

When seen at the Gynecology Tumor Clinic at University Hospital on November 18, the patient appeared to be thin, pale, and chronically ill, but she had normal vital signs. Abdominal examination revealed a firm, nontender, movable pelvic mass extending up to the level of the umbilicus. Pelvic examination revealed a fungating mass filling the upper half of the vaginal canal. The vaginal mass was in contiguity with the abdominal mass and the diagnosis of mixed mesodermal sarcoma was made by biopsy of the vaginal mass. After admittance to the hospital, x-ray of the chest, intravenous pyelogram, sigmoidoscopy and barium enema examinations were negative; hemoglobin was 5.5 Gm. per 100 ml. and hematocrit 20 per cent. Multiple transfusions were given to restore her volume to normal. She was then treated with cobalt teleotherapy, receiving a total dose of 5000 roentgens to the mid-pelvis.

On February 1 the patient was re-admitted to the hospital for definitive surgical therapy. At this time pelvic examination revealed the pelvic tumor mass to have shrunk 50 per cent. She was subjected to a total hysterectomy, bilateral salpingo-oophorectomy on February 2 and was discharged from the hospital on February 11.

### Comments

In the past at University Hospital, sarcoma has been treated by total hysterectomy and bilateral salpingo-oophorectomy followed by external irradiation in certain cases. It was elected to give this patient preoperative irradiation in anticipation of shrinking the total tumor mass, fibrosing vascular and lymphatic channels, creating a more bacteriostatic field, and, hence, making the technical procedure less difficult to perform.

One of the most difficult problems facing the clinician today is educating the public to recognize and report without delay, signs and symptoms which are commonly associated with malignant tumors in the pelvis. It is of equal importance for the lay person to report to her physician for an annual pelvic examination and Papanicolaou smear whether or not she has pelvic symptoms. In the present case, not only did the patient fail to appreciate the latter, but she also ignored vaginal bleeding for one year.

*Patient Delay:* One year.

*Physician Delay:* None.

SHOCK IN HEAD INJURY.—Shock does not frequently coexist with head injury. Its presence in a patient with a head injury is strongly presumptive of injury elsewhere in the body.—*Southern Medical Journal,* 55:513-517, 1962.




# NEWS AND Organization Section

# Proceedings of The Council

## Preliminary Data for Formation of Payment-in-Full Plan Discussed; Other Important Business Transacted

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the Columbus Office on Saturday afternoon, July 14, and Sunday, July 15, 1962. The following were in attendance in addition to members of The Council: Drs. Edwin H. Artman, Chillicothe, John H. Budd, Cleveland, George A. Woodhouse, Pleasant Hill, Edmond K. Yantes, Wilmington, delegates to the AMA; Drs. P. John Robechek, Cleveland, Frederick P. Osgood, Toledo, J. Robert Hudson, Cincinnati, Robert S. Martin, Zanesville, Harry K. Hines, Cincinnati, alternate-delegates to the AMA; Mr. Charles H. Coghlan, Mr. Frank W. Van Holte, Dr. R. Dean Dooley, Columbus, representing Ohio Medical Indemnity, Inc.; Dr. Perry R. Ayres, Columbus, Editor *The Ohio State Medical Journal;* Mr. Wayne E. Stichter, Toledo, legal counsel; Mr. John Norris, Cincinnati, a preceptee under the preceptorship program of the Ohio State Medical Association Committee on Rural Health, now residing with Dr. Edmond K. Yantes, Wilmington; Messrs. Nelson, Saville, Page, Edgar, Moore and Traphagan from the headquarters office staff.

### Minutes Approved

The minutes of the meetings of The Council held on April 29 and May 16 were approved by official action.

### Membership Report

The Executive Secretary presented membership statistics as follows: total membership as of June 30, 1962, 9,454, of which 8,506 are affiliated with the American Medical Association; compared to a total membership on December 31, 1961 of 9,530 of which 8,614 were AMA affiliates.

### OMI Payment-In-Full Plans

Following oral reports by members of The Council, The Council considered the following resolution which was adopted by the House of Delegates at the 1962 Annual Meeting, May 14-18, Columbus:

WHEREAS, Blue Shield plans offered through the facilities of Ohio Medical Indemnity, Inc., are intended and planned for the benefit of patients, and

WHEREAS, Ohio Medical Indemnity, Inc., has been unable to retain contracts under certain competitive conditions, therefore,

BE IT RESOLVED, That Ohio Medical Indemnity, Inc., be authorized to offer an expanded indemnity plan which may be presented as a payment-in-full contract to groups who qualify by certain income limitations and when the service is rendered by a voluntarily participating physician.

For subscribers whose income exceeds the agreed limit the benefit will be an indemnity only.

When the physician is a non-participant the scheduled indemnity is still paid and the physician is free to bill the patient for the balance of his fee.

There was a lengthy discussion and consideration of data with respect to the family gross income of residents of the State of Ohio and similar data. Statistics with respect to the coverages now being offered by other Blue Shield Plans throughout the nation were considered. The discussion also involved questions of indemnity benefits, premiums to be charged and underwriting regulations. Some of the legal aspects were discussed by Mr. Stichter. Detailed information based on their experience was presented by the rep-

resentatives of OMI, Mr. Coghlan, Mr. Van Holte and Dr. Dooley. Members of The Council offered comments regarding reactions and opinions of physicians in their respective Councilor Districts.

By official action, **The Council requested the Board of Directors of Ohio Medical Indemnity to develop several possible plans,** which could be considered by The Council at its next meeting, as the basis for a proposed Ohio State Medical Association payment-in-full plan which would be presented to the membership of the Association for consideration. It also specified that this material should be made available to members of The Council on or before September 10 and that the packet should include information regarding the plans now being offered by the Blue Shield Plans in a number of selected states.

### Review of 1962 Annual Meeting

The Council reviewed the 1962 Annual Meeting held in May. The consensus was that in general the 1962 Annual Meeting was quite successful. Council expressed the hope that the various specialty groups would continue to integrate their meetings with that of the OSMA.

### Plans for 1963 Annual Meeting

The Executive Secretary reported that the Committee on Scientific Work, the section officers and officials of the various specialty groups would meet in the headquarters office on Saturday and Sunday, August 25 and 26, to develop plans for the 1963 Annual Meeting to be held in Cleveland the week of May 12.

On recommendation of the OSMA staff, after a careful survey of Cleveland facilities **The Council voted** that the entire meeting should be held in the enlarged Sheraton-Cleveland Hotel, which will have ample accommodations for the OSMA meeting as well as the meeting of the Woman's Auxiliary.

A letter from Mrs. Edward Bauman, Warren, president of the Woman's Auxiliary to the Ohio State Medical Association, indicating that the Auxiliary would be happy to hold its meeting at the Sheraton-Cleveland Hotel if it met with the approval of The Council, was read and discussed. The Council voted such approval.

**The Council also adopted** a suggested format for the 1963 Annual Meeting to be presented to the Committee on Scientific Work as The Council's recommendation for the schedule of events for the 1963 meeting.

### Time and Place for Future Annual Meetings

The Council considered the possible time and place for meetings in 1966, 1968, 1970 and 1972. It was pointed out that the 1964, 1965, 1967, 1969 and 1971 meetings will be held in Columbus. By official action, The Council voted to hold the 1966 meeting the week of May 22 and the 1968 meeting the week of May 12 in Cleveland, unless there is an improvement in the convention facilities in Cincinnati. It was decided not to select the place for the 1970 and 1972 meetings at this time inasmuch as there are reports that within several years, Cincinnati will have a convention hall or other more adequate convention facilities.

### Report on AMA Meeting in Chicago

A report on the recent AMA meeting in Chicago was presented by Dr. Woodhouse, chairman of the Ohio AMA delegation, and by individual delegates and alternates in attendance. It was pointed out that a detailed story on the meeting had been published in the July issue of *The Ohio State Medical Journal* and had been mailed to all members of The Council.

### Annual Meeting Resolutions Referred to Committees

Three resolutions which had been considered by the House of Delegates at the recent OSMA Annual Meeting, relating to ethical questions and entitled: Medical Center, Free Choice and Medical Ethics, were referred by The Council to the Judicial and Professional Relations Committee for investigation and a report back to The Council.

A resolution regarding possible additions to the OSMA staff by establishing several field secretaries was referred to the Committee on Auditing and Appropriations for study and a report back to The Council. Members of The Council indicated that this might be a good topic for discussion at the afternoon sessions of the Councilor District Conferences to be held in the Fall of 1962.

### County Society Articles of Incorporation And Code of Regulations Approved

By official action, The Council **approved** the amended and revised Articles of Incorporation and Code of Regulations of the Academy of Medicine of Cincinnati.

By official action, The Council approved the Articles of Incorporation and Code of Regulations adopted by the Jefferson County Medical Society, which Articles and Regulations were filed with the Secretary of State on March 15, 1962.

By official action, The Council approved an amendment adopted by the Lorain County Medical Society making minor changes in Chapter IV, Section 3, paragraph (d) and Chapter IV, Section 6, of the Bylaws of that society, and adopted by that society on or about May 11, 1962.

### Fall District Conferences

Mr. Saville discussed the plans which had been made for the series of Fall Councilor District Conferences. He pointed out that the evening sessions would be confined entirely to legislative and political

matters. Members of The Council were requested to offer suggestions for topics which might be discussed at the afternoon sessions. He pointed out that officials of the various county medical societies had been notified of these meetings and that in the very near future legislative questionnaires would be sent to the local chairmen for the purpose of securing data about the candidates for public office.

### American Medical Political Action Committee

By official action, The Council expressed the opinion that it is not necessary for Ohio to organize a State American Medical Political Action Committee at this time and that the question of whether it would be necessary to organize AMPAC setups in some of the Congressional Districts should be decided by the physicians in those particular areas.

By official action, The Council expressed the belief that individual physicians should continue to contribute as liberally as possible to the national AMPAC so that funds could be made available from that source to areas needing financial help in their political activities.

### National Legislation

Mr. Nelson and Mr. Saville presented a report on their visit to Washington, July 11 and 12, at which time they interviewed most of Ohio's Congressmen.

### New Committee on Medicine and Religion

A letter from Rev. Dr. Paul B. McCleave, AMA Department of Medicine and Religion, asking the Ohio State Medical Association to establish a new committee or direct an existing committee to head up activities in Ohio in the field of medicine and religion and to select three counties which could be used as pilot counties by the AMA for a trial program in this area during the Fall of 1962, was read and discussed.

On authorization of The Council, Dr. Hamwi appointed Dr. Petznick as chairman of a committee to be known as the Committee on Medicine and Religion. Dr. Petznick is at the present time a member of the Advisory Committee to the AMA Department of Medicine and Religion. It was agreed that Dr. Hamwi and Dr. Petznick should select the other members of the committee at a later date and that Dr. Petznick and his committee should give prompt consideration to the selection of the three pilot counties.

### Veterans Administration Fee Schedule

A communication from a member, stating that in his opinion fees paid by the Veterans Administration for a cardiac examination, including electrocardiogram, and X-ray of chest, PA and lateral, with report, respectively $15.00 and $10.00, are entirely inadequate, was read and discussed.

The Executive Secretary was instructed to get in touch with the Veterans Administration on this matter and make a report to The Council at its meeting in September.

### Ohio Nursing Home Association Request

A letter from the Ohio Nursing Home Association, requesting the OSMA to appoint a representative on its Advisory Council, was read and discussed. Dr. Hamwi, the President, was authorized to make such appointment.

### Handling of Grievances in the Counties

Members of The Council were encouraged to secure more information from their county medical societies on the matter of how grievances are handled or should be handled. Reference was made to the questionnaire developed by the Judicial and Professional Relations Committee which is seeking basic data before formulating definite recommendations on this subject.

### The Ohio State Medical Journal Financial Condition

A report on the financial condition of *The Ohio State Medical Journal* was presented by Mr. Moore, assistant business manager. The Council was advised that more detailed information would be available for consideration by The Council later in the year.

### Transfer of Funds

The Council, by official action, authorized the transfer of certain funds within the appropriation of the Department of Public Relations in order to take care of certain deficiencies in several specific items.

### Federal Proposal

A communication asking the Association to present certain testimony on H.R. 10606 now pending in the Senate Finance Committee, was discussed. By official action, The Council expressed the opinion that adequate testimony had been presented by the American Medical Association and the National Foundation for Eye Care.

### Report of Committee on Disaster Medical Care

Mr. Traphagan, reporting for the Committee on Disaster Medical Care, advised that the Ohio State Medical Association had been requested to co-sponsor, with the Ohio Department of Health and the Ohio Hospital Association, a Health Mobilization Training Course, tentatively set for November 11-12. He stated that the OSMA would not be involved financially. By official action, The Council approved this request that the OSMA be a co-sponsor of the course.

### Ohio Cancer Coordinating Committee Report

Minutes of a meeting of the Board of Trustees of the Ohio Cancer Coordinating Committee, Inc.,

were presented by Mr. Edgar. The minutes were approved by official action. It was pointed out that it was necessary to incorporate the Cancer Coordinating Committee in order to receive and make use of a $2,000.00 grant from the Ohio Department of Health to be used to help pay the expenses of speakers sent into areas for the purpose of stimulating interest in the establishment of Cancer Registries.

### National Council on Aging Request

A communication, asking the Association to affiliate with the National Council on Aging, was read and discussed. By official action, The Council expressed the belief that the AMA would be the proper body to represent medicine on such an organization, if such representation is deemed necessary and appropriate.

### New Mental Hygiene Law

A letter from Dr. Victor M. Victoroff, Cleveland, chairman of the Ad Hoc Committee for Mental Health Legislation of the Academy of Medicine of Cleveland and Cuyahoga County, asking the assistance of the OSMA in a poll of physicians regarding possible revisions or amendments in the new Ohio Mental Commitment Law, was considered. The Executive Secretary was authorized to advise Dr. Victoroff that the Association would be willing to send a one-page questionnaire which he might design, to members with a mailing of the OSMAgram so that members could express their views; but that no OSMA funds would be made available for return postage.

### Health Careers Week in Ohio

A communication from Mrs. E. E. Bauman, Warren, President of the Woman's Auxiliary to the Ohio State Medical Association, on the subject of health careers and whether or not a Health Careers Week should be established and proclaimed by the Governor, was considered.

By official action, The Council approved, in principle, the Health Careers Week, but felt that this activity should be on a local basis and co-sponsored by the county medical society and the local auxiliary, with the cooperation of the local hospital or hospitals. Members of The Council expressed the opinion that there would be no objection to having the Health Careers Week activity the same week in all local areas, if possible, but that this probably would be an insurmountable organization problem. It was felt that a Governor's proclamation would not be feasible as the time of activities locally would vary.

There being no further business, The Council then adjourned to meet at the Granville Inn, Granville, Ohio, September 21, 22 and 23.

Attest: CHARLES S. NELSON
*Executive Secretary*

## Recent Opinions Rendered by The Attorney General

Following are sillibi of recent opinions given by Attorney General Mark McElroy:

1. Except as provided in Chapter 1785., Revised Code, dealing with professional associations, a corporation whether organized for profit or not for profit, which employs a licensed dentist under an arrangement which contemplates profit or gain, as opposed to charity, is a "manager, proprietor, operator, or conductor" within the meaning of said terms as defined in Section 4715.01, Revised Code, and since such corporation could not be licensed to practice dentistry, its operation would be unlawful.

2. Under Section 4715.01, Revised Code, the license of a licensed dentist who is employed by such a corporation is subject to revocation.

3. The determination of whether the employment of a licensed dentist by a hospital corporation causes such corporation to be practicing dentistry as defined in Section 4715.01, Revised Code, is based upon whether the arrangement is one in which a profit or gain is a moving factor causing such employment. (Opinion No. 2235, Opinions of the Attorney General for 1947, page 468, approved and followed.)

4. Where a non-profit corporation is operated in a fashion where its members or employees practice dentistry for which fees are charged by or through such corporation, and if such corporation makes distribution of such fees as salaries and bonuses, such corporation is practicing dentistry as defined by Section 4715.01, Revised Code.

* * *

An inspector of the state board of pharmacy would not have the authority under Sections 3719.05, 3719.26, and 3719.27, Revised Code, to remove from the records required to be kept by a pharmacist under the provisions of those sections, a prescription for narcotics or barbiturates for use as evidence, except when such evidence is taken as a result of lawful search incident to a lawful arrest of the pharmacist so required to keep such records, for a violation of the law which would cause such records to be useful as evidence. — Opinion No. 3039.

* * *

A county coroner may adopt or utilize a facsimile signature for all documents, reports, writs, and correspondence, other than death certificates, which he executes or signs pursuant to his duties under Chapter 313., Revised Code; but under Section 3705.03, Revised Code, a facsimile signature may not be used to sign a death certificate. — Opinion No. 3029.

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According to the National Library of Medicine, there were almost 6,000 medical journals published throughout the world in 1960, compared with 850 in 1879.

# Mr. Carey Issues a Challenge...

## Are You Prepared To Meet It? Are You Ready To Work For And Elect To Congress Those Who Believe As You Do?

**NEWS** from **INDUSTRIAL UNION DEPARTMENT, AFL-CIO**

815 SIXTEENTH STREET, N. W., Washington 6, D. C. • EXecutive 3-5581

July 13, 1962

IMMEDIATE RELEASE:

Following is a statement of James B. Carey, secretary-treasurer, Industrial Union Department, AFL-CIO, on the old age health care Senate vote:

"The American Medical Association and its allies have won again, but the unmet health care needs of the nation's senior citizens will not disappear from the nation's sight.

"As long as those needs remain, the issue will not die and the fight will go on. The people will have the last word and will prevail despite the callous disregard for their welfare demonstrated by the GOP-Dixie combine which has just shown its teeth in the Senate.

"The industrial unions and their members have long carried on this fight, and will now redouble their efforts. They are not so hard-hearted as the AMA. They are willing to pay their share through social security so that their elders may have more adequate care.

"The AMA has fooled nobody in this fight, although it has shown its power to impose its own brand of political medicine upon us. The aged, ill and infirm will not forget the treatment they have just received at the hands of their doctors.

"Nothing is more phony than AMA's cry of socialized medicine. There is no more socialism to the social security system than in Blue Cross or any other pooling of hospital costs. Retired members of the AMA may be able to pay for the kind of care officially blessed by that organization. Retired working people cannot.

"The health care issue will loom large in November. We shall not forget how the vote was cast on the old age health care issue."

###

*"The only thing necessary for evil to triumph is that good men do nothing" — Edmund Burke*

# Public Health and the Radiation Hazard

H. GARDNER BOURNE, JR., B. S. C. E.*; JAMES C. WYND, M. S.**;
and RALPH E. DWORK, M. D.†

MAN throughout the ages has been exposed to ionizing radiation. Prior to the discovery of x-rays in 1895 his exposure was limited to natural background radiation, the ionizing radiation from naturally occurring radionuclides as they exist in nature plus cosmic radiation from outer space. This natural background radiation includes all common types of ionizing radiation although the primary exposure is to penetrating x- and gamma radiation. All foodstuffs are "contaminated" to some extent with natural radioactive materials so that there is a continual intake to the body. Table 1 indicates some of the measured values of background radiations.

TABLE 1. *Estimated Background Radiation*

| Radiation type or Source | Soft tissue dose, Millirem/year |
|---|---|
| Cosmic rays: | |
| Sea level | 30 |
| 5,000 feet | 50 |
| External gamma: (All sources) | |
| Out of doors | 50-100 |
| In buildings: | |
| Wood | 60-65 |
| Brick | 110-125 |
| Concrete | 180-230 |
| Internal emitters: | |
| Carbon-14 | 2 |
| Potassium-40 | 2 |

The average annual population dose due to natural background radiation is of the order of 100 millirems per year and cannot be controlled or reduced.

The discovery of x-rays resulted in the first addition to the natural background radiation of a man-made source of ionizing radiation. The exposure to the general population from this new source has been gradually increasing. That this is due largely to the increased use of x-rays in the healing arts is shown in Table 2 where the annual whole-body dose of radiation received externally by an average individual of the United States from medical and dental x-ray sources is estimated for the period from 1925 to 1955.

The continued upward trend exhibited by this x-ray data suggests the likelihood that the current exposure of the population from x-ray apparatus will increase still further, unless appropriate radiation control measures are put into practice.

*Mr. H. Gardner Bourne, Assistant Division Chief for Engineering, Division of Industrial Hygiene, Ohio Department of Health, Columbus.
**Mr. James C. Wynd, Chief, Radiation Engineering Unit, Division of Industrial Hygiene, Ohio Department of Health, Columbus.
†Dr. Ralph E. Dwork, Director, Ohio Department of Health, Columbus.

**The accompanying article was prepared at the request of the Committee on Radiation of the Ohio State Medical Association and is published under the sponsorship of the committee. Additional articles on the subject of radiation hazards will be sponsored by the committee from time to time.**

### Man-Made Contamination

Man-made environmental contamination from radioactive fallout has received considerable attention over the past decade. When there is a nuclear explosion in the megaton range, the gases cool so slowly that a major portion of the fission products enter the stratosphere where they are distributed widely. These fission products drift back into the troposphere rather slowly but some of the short-lived radionuclides still reach ground level before losing their radioactivity and are deposited at ground level in patterns which depend at least in part upon meteorological conditions. For example, during September and October of 1961 following resumption of nuclear detonations by the U. S. S. R. radioactive iodine (half-life of 8 days) appeared in milk. On October 2, 1961, 730 micromicrocuries/liter of iodine - 131 were measured in processed milk in Omaha, Nebraska. On the same day only 10 micromicrocuries per liter were reported in Washington, D. C. The Department of Health, Education, and Welfare said on November 24, 1961, that "radioactive iodine levels in air, water, milk and other foods were not high enough anywhere in the country to justify general use of non-radioactive

TABLE 2. *Estimated Whole-Body Dose Received Externally from X-ray Sources*

| Year | Millirems/Year |
|---|---|
| 1925 | 15 |
| 1935 | 40 |
| 1945 | 75 |
| 1955 | 135 |

compounds to block the uptake of radioactive iodine by the thyroid gland." This statement was issued in the form of an interim report to state and territorial health departments and to national medical organizations, pending completion of special studies of various counter measures which might be taken if fallout levels were to reach a point where individual or public action to reduce exposure would need to be considered.

### Long-Lived Nuclides

Although, as has been said, some fission products drift back into the troposphere shortly after the nuclear detonation, the final fallout takes a long time to return to earth so that the fission products from this stratospheric source consist mainly of the long-lived nuclides: such as strontium-90 (half-life of 28 years) and cesium-137 (half-life of 27 years). Milk is a major source of human in-take of strontium-90 and cesium-137.

Table 3 shows the quantity of strontium-90 and cesium-137 in raw milk at Cincinnati, Ohio during the past five years.

TABLE 3. *Average Concentration of Strontium-90 and Cesium-137 in Monthly Raw Milk Samples in Cincinnati, Ohio*

| Year | Micromicrocuries per liter Strontium-90 | Cesium-137 |
|---|---|---|
| 1957 | 5.9 | 39 |
| 1958 | 8.5 | 48 |
| 1959 | 12.8 | 37 |
| 1960 | 9.9 | 23 |
| 1961* | 9.0 | 16 |

*Through June, 1961.

It will be observed that the maximum values were reached in 1958 and 1959. Nuclear detonations ceased in 1958 and were not again resumed until the fall of 1961. It is expected that the values will again increase during the late spring of 1962 following the U. S. S. R. detonations in the fall of 1961.

### Upward Trend Predicted

It has been estimated that fallout would contribute about 2 millirems per year to the per capita dose of the population if nuclear weapons testing in the atmosphere was not resumed after the cessation at the end of 1958. If testing had continued at the same rate as in the five years prior to 1958 the per capita contributed dose would be estimated to be 16 millirems per year. For the present we have no alternative but to assume that the man-made environmental contamination will show an upward trend.

In addition to natural background, medical and dental x-rays, and man-made environmental contamination, there are other sources contributing to the population exposure such as the radiation to which some workers are exposed during their working hours, the radiation to which bystanders and residents in the vicinity of industrial and medical radiation installations are exposed and radiation from miscellaneous sources such as radium-dialed watches, television sets and so forth. The whole-body dose to the average member of the general population per year from such sources has been estimated to be of the order of 5 millirems.

The relative present contribution of the various sources of ionizing radiations to the whole-body dose of mankind per year is summarized in Table 4.

TABLE 4. *Radiation Sources of Whole-Body Dose Per Year*

| Source | Man-Rems Per Million Persons |
|---|---|
| Natural Background | 100,000 |
| Medical & Dental | 150,000-300,000 |
| Occupational | 5,000 |
| Plant Environs | 5,000 |
| Fallout | 7,000- 15,000 |
| Total | 270,000-430,000 |

It is obvious that radiation encountered in the healing arts is the greatest single contributor to man's whole-body radiation dose. This source of exposure is amenable to further reduction. Natural background, second in importance, cannot be reduced. Fallout, third in significance, is most effectively subject to control by international agreement.

### Fallout Hazards

The effects of radiation from fallout may be mitigated by various means, yet each remedy thus far proposed entails either some risk in itself or an economic burden. Thus far it has not been deemed necessary to institute counter measures. However, national fallout surveillance has been increased — particularly milk surveillance. The extent of contamination of Ohio milk with radioactive strontium, cesium, and iodine is a source of apprehension to the Ohio Department of Health. A partial appraisal of the contamination of milk in Ohio is available from Public Health Service measurements on Cleveland and Cincinnati milk. The Department believes this to be inadequate state coverage and considers it essential that the State of Ohio develop a capability to ascertain significant radionuclides in milk produced in the several Ohio milksheds. Unfortunately, this need has not yet been adequately appreciated in other areas of state government.

To halt the upward trend in man's exposure to ionizing radiation the most productive area is the reduction of exposure in the healing arts. To accomplish this is, for the present, the first goal of the Department. The regulations of the Public Health Council which became effective January 1, 1962, requiring the registration of persons who produce, use, store or dispose of radiation sources is an important first step in a planned program to reduce x-ray exposure in the healing arts. How this may be accomplished without interfering with the professional judgment of the physician or dentist will be discussed later.

### Reasons for Concern

Why are we now so concerned about the radiation exposure from x-rays used in the healing arts when

their use goes back to 1895? The answer is that, (1) only in recent years have we acquired the knowledge of the damaging effect of chronic exposure to low levels of radiation over a protracted period of time; (2) the exposure of the population to x-rays used in the healing arts has been steadily increasing; and (3) we must allow for some increase in the population exposure which will naturally accompany the ultimate utilization of nuclear energy. In terms of numbers observe the decrease in recommended annual maximum permissible dose in rems for workers occupationally exposed to ionizing radiation as shown in Table 5.

TABLE 5. *Recommended Maximum Permissible Dose for Occupational Radiation Exposure*

| Period | Annual Permissible Dose in Rems |
|---|---|
| 1931-1936 | 60. |
| 1936-1948 | 30. |
| 1948-1958 | 15. |
| 1958-present | 5. |

These figures, remember, refer to occupational exposures. For large segments of the population exposed in the environs of radiation installations, the maximum permissible dose is 0.5 rems. These limits are exclusive of radiation exposures that are received from medical and dental procedures.

## Working Assumptions

For the general population chronic exposure involves both somatic and genetic risk. Geneticists consider the radiation genetic effect to be directly proportional to the number of genetic changes induced in the parental germ cell. It has been well demonstrated that the curve showing effect against dose in experimental animals is linear within the range of 37r to 1,000r total acute dose, and geneticists believe that there is no threshold for the genetic effect. Hence, it has been deemed wise to make the following working assumptions: radiation induced mutations, at any given dose rate, increase in direct linear proportion to the genetically significant dose; mutations, once completed, are irreparable; almost all the observed effects of mutations are harmful; radiation-induced mutations are, in general, similar to naturally occurring mutations; and, there is no known threshold dose below which some effect may not occur.

## No General Agreement

For somatic effects, unlike genetic mutation effects, there is no general agreement among scientists on the dose-effect relationship. It is known, for example, that the nature of the dose-response curve can be altered drastically by changes in the external environment of the organism. In addition, although radiation may be the initiating event, there may be other promoting factors operating before the manifestation is evident. Such factors mentioned in the literature include co-carcinogens, hormones, chemicals and viruses.

## Federal Policy

It is now the opinion and working philosophy of the Federal Radiation Council that no exposure to radiation should be permitted unless it satisfies two criteria:

(1) The various benefits to be expected as a result of the exposure, as evaluated by the appropriate responsible group, must outweigh the potential hazard or risk, and

(2) The reason for accepting or permitting a particular level of exposure rather than reducing the exposure to a lower limit must outweigh the decrease in risk to be expected from reducing the exposure.

## Ohio's Statute

The Department believes that the individual physician or dentist is the "appropriate responsible group" who must weigh benefit against risk and in fact this right of the physician or dentist is guaranteed in the Ohio radiation statute (R. C. Sec. 3701.96) wherein it states "Sections 3701.90 to 3701.98, inclusive, of the Revised Code shall not be construed to limit the kind and amount of radiation that may be intentionally applied to a person for diagnostic or therapeutic purposes by or under the direction of a physician or dentist."

To fulfill this responsibility of weighing benefit versus risk the following precepts should be considered:

(A) There should be clear-cut clinical indications before any x-ray examination is undertaken, and it should be ascertained whether there has been a previous radiological examination which would make further examination unnecessary.

(B) To reduce unnecessary examination, arrangements should be made for ready availability of previous films.

(C) All requests for examination should state precisely the clinical indications and the information required.

(D) There should be consultation between clinician and radiologist before extensive or repeated radiological examinations of young individuals are undertaken.

(E) To reduce the necessity of repeat investigation strict attention should be paid to adequate preparation of the patient before abdominal investigation.

(F) Special precautions should be adopted in the radiography of pregnant women. Only essential examination should be carried out during pregnancy and particular care should be taken to avoid irradiation of the foetus whenever possible.

(G) Any previous history of radio-therapy should be ascertained before a new course of treatment is undertaken.

(H) Consideration should always be given to al-

ternative methods of treatment before radio-therapy of non-malignant conditions is undertaken.

### Second Criterion

The Federal Radiation Council's second criterion, namely, the reason for accepting or permitting a particular level of exposure rather than reducing the exposure to a lower limit must outweigh the decrease in risk to be expected from reducing the exposure, is pertinent to medical and dental professions. It is the belief of the Department that, frequently, alterations or additions to existing medical and dental x-ray equipment and further refinements of operation technique will result in lower exposure to the physician, the patient, the physicians' employees and in some cases the public without sacrificing the quality of the radiograph or the fluorographic views.

This opinion of the Department is confirmed by the results obtained in New York City where inspection of clinical x-ray equipment has been carried out on an intensive scale since 1959. Table 6 provides an

TABLE 6. *Inspection Statistics for Clinical X-Ray Units in New York City*

| Type of Unit | No. | % of Units Inspected in Each City |
|---|---|---|
| **Medical fluoroscopic** | **(1687)** | |
| Shutters did not adequately limit x-ray beam | | 59.5 |
| Required timer not installed | | 32.0 |
| Inadequate filtration | | 19.4 |
| Dark adaptation goggles not available | | 15.8 |
| **Medical radiographic unit** | **(1648)** | |
| Excessive beam size (chest x-ray) | | 66.0 |
| Inadequate filtration | | 25.0 |
| Inadequate protection for operator | | 63.0 |
| **Medical therapy unit** | **(127)** | |
| Inadequate tube shield (obsolete type) | | 4.0 |
| Inadequate identification filters | | 19.7 |
| Inadequate timers | | 14.2 |
| **Dental radiographic unit** | **(2716)** | |
| Excessive beam size | | 27.5 |
| Inadequate filtration | | 33.7 |
| Inadequate protection for operator | | 5.0 |

insight into some of the most common defects in diagnostic and therapeutic x-ray equipment found in New York City.

### How To Reduce Exposure

In general it may be said that the following recommendations if followed will reduce exposure in diagnostic and therapeutic radiological practice without detriment to the value of these procedures and without transgression of the professional judgment of the physician or dentist in balancing benefit-risk relationship.

1. Strict limitation of field size to the area necessary for the particular examination or treatment should be routinely practiced.

2. Whenever possible the beam should not be directed towards the gonads.

3. Adequate gonadal shields should invariably be used in examinations or treatments which are likely to give high gonadal dose.

4. In the examination or treatment of children or patients who need support, mechanical devices to ensure immobilization should be used.

5. The use of the fastest films and screens consistent with satisfactory diagnostic value is strongly recommended.

6. Repeat exposures should be kept to a minimum by the use of accurate electric timers and by careful handling and development of x-ray films.

7. Adequate filtration of the useful x-ray beam should be provided to filter out "soft" x-rays which contribute nothing to the film or fluorescent image.

8. Fluoroscopy should not be undertaken if the same clinical information can be obtained by radiography.

9. No fluoroscopic examination should be undertaken without adequate dark adaptation — at least 10 minutes.

10. All fluoroscopy machines should be fitted with a timing device which automatically cuts off the beam or sounds an audible signal after a certain time or dose.

11. In the treatment of skin conditions, use should always be made of the softest quality of radiation consistent with adequate irradiation of the tissues to be treated.

12. Checks should be made regularly to ensure that all radiological equipment is adequately maintained. Obsolete and erratic equipment should be replaced immediately.

### Program Being Developed

The Department is well aware that many physicians and dentists are familiar with the genetic hazard of ionizing radiation and are using modern equipment and techniques which insure the lowest possible dose consistent with satisfactory diagnostic or therapeutic value. Unfortunately this state of knowledge and its application is not universally shared in the healing arts. Hence, the Department, in the interest of public health, is in the process of developing a program whereby assistance will be given on a voluntary basis to interested physicians and dentists who may wish to learn if their equipment and procedures meet the best in good practice at the present time. To insure that such a program will meet both the needs of the healing arts and at the same time respect the professional judgment of the physician and dentist, we will be guided by the judgment of the Radiation Advisory Council appointed by the Director of Health, the Committee on Radiation of the Ohio State Medical Association and the Radiation Committee of the Ohio Health Commissioners Association.

It has been said that our most valuable bequest to future generations is contained in our genes and that this hereditary material should be handed to our descendants in as good a condition as it was received from our forebearers. Increasing exposure to ionizing radiation is a threat to the inheritance of our posterity. The medical professions have both a direct responsibility and a unique opportunity of insuring that ionizing radiation will not prove a liability to future man.

# Excellent Array of Postgraduate Courses Offered in Ohio

EXCELLENT Postgraduate courses are offered in various parts of Ohio this Fall giving physicians a variety of subjects to choose from. Some of the programs scheduled are annual events, well known to physicians in the area. Others are scheduled to fulfill particular needs. Physicians in respective areas where programs are scheduled will want to join their colleagues regardless of organization affiliation. Other physicians may wish to scan the subject matter and list of speakers for programs of particular interest.

Following are the programs announced to *The Journal* before this issue went to press. Additional information will be published in subsequent issues on other programs scheduled later in the season. The list is arranged chronologically.

September 11 (weekly)—**Central Ohio Heart Association,** Clinical Electrocardiology.

September 14-15—**Ohio Chapter, American College of Surgeons,** Annual Meeting, Youngstown.

September 15—**Ohio Society of Pathologists,** Cincinnati.

October 5—**Association of Physicians of the Ohio Department of Mental Hygiene and Correction,** Columbus.

October 11—**Northwestern Ohio Medical Association,** Annual Meeting, Findlay.

October 18-20—**Ohio Academy of General Practice,** Annual Assembly, Columbus.

October 24—**Sixth Councilor District Postgraduate Day,** Akron.

October 24—**Ohio Psychiatric Association,** Cincinnati.

October 26-28—**American Heart Association,** Annual Meeting and Scientific Session, Cleveland.

November 19—**Academy of Medicine of Columbus and Franklin County,** Clinic Day Type Program, Columbus.

* * *

## Clinical Electrocardiology Course Is Offered

A 10-week postgraduate course in clinical electrocardiology for practicing physicians will be offered by the Central Ohio Heart Association at Riverside Methodist Hospital, Columbus. Classes will begin September 11 and be held each Tuesday from 7:00 to 9:00 p. m.

## Ohio Society of Pathologists Fall Meeting Scheduled

The fall meeting of the Ohio Society of Pathologists has been scheduled for Saturday, September 15, in Cincinnati. The program, beginning at 1:30 p. m. will be in the Pathology Amphitheater, Department of Pathology, Cincinnati General Hospital. Dinner will be at the Alms Hotel, William H. Taft Road and Victory Parkway. Moderator will be Dr. Fred W. Stewart, Memorial Hospital, New York City.

The program includes the following features:

**Focal Cerebral Necrosis in Premature Newborn Infants with Jaundice (Schmorl's Disease),** Eugene V. Perrin, M. D.

**Myocardial Infarction in Association with Varied Steroid Patterns,** Bernard C. Wexler, Ph. D.

**Canine Cushing's Disease,** David L. Coffin, D.V.M.

**Chronic Carbon Tetrachloride Poisoning—Electron Microscopic Observations,** Richard J. Stenger, M. D.

**Slide Seminar,** Dr. Stewart.

* * *

## Ohio Surgeons Schedule Program In Youngstown, Sept. 14-15

The seventh annual meeting of the Ohio Chapter of the American College of Surgeons will be held Friday and Saturday, September 14-15, at the Hotel Pick-Ohio, Youngstown. Sections represented will be General Surgery, Urology, Neurosurgery, and Obstetrics and Gynecology.

Discussion of current trends in the management of melanoma, "How I Do It" clinics and presentation of papers by the winners of the Resident Essay competition, will feature the opening morning session on Friday. Dr. George W. Stephenson, assistant director of the College, will lead the discussion of current trends in graduate training in surgery in community hospitals, following luncheon.

Friday afternoon session will include panel discussions on current trends in the management of gastroduodenal, procto-colonic and pediatric problems. A symposium on current trends in treatment of burns and their complications will conclude the afternoon program.

On Friday evening a cocktail hour and dinner will be held, followed by entertainment.

Sections will meet on Saturday morning, after which the entire group will hear a panel discussion on Cur-

*(Continued on Next Page)*

(Ohio Surgeons — Contd.)

rent Trends in the Management of Advanced Carcinoma, to be moderated by Dr. George T. Pack of New York.

Dr. Frank Shively, Dayton, is Chapter president, and Dr. Tom Lewis, Columbus, secretary. Dr. Stanley O. Hoerr, Cleveland, will be installed as incoming president during the business meeting Friday afternoon. Dr. Stephen W. Ondash, Youngstown, is State chairman. Executive committee for the meeting arrangements includes Drs. Oscar Turner, Fred Schlect, A. K. Phillips, J. J. McDonough, Gordon Nelson, William Flynn and Robert McConnell.

* * *

## Physicians in State Mental Hygiene Work To Meet

The annual scientific meeting of the Association of Physicians of the Ohio Department of Mental Hygiene and Correction will be held on Friday, October 5, at the Columbus State Hospital, Columbus.

* * *

## Northwestern Ohio Medical Association Program

The Northwestern Ohio Medical Association, composed of physicians of the Third and Fourth Councilor Districts, has announced its annual meeting to be held on Thursday, October 11 at the Findlay Country Club, Findlay, Ohio. The program will be in the form of a Symposium on Practical Medicine and Surgery for the Female Patient. Registration begins at 9:00 a. m. with the first program feature at 10:00 a. m. Wives of physicians are welcome to attend a reception in the Lounge between 5:00 and 6:00 p. m.

The program has been announced as follows:

### Morning Program

Moderator: Dr. William G. Hartnett, Fostoria.

**The Role of the Endocrinologist,** Dr. E. C. Hamblen, professor of endocrinology and associate professor of obstetrics and gynecology, Duke University School of Medicine.

**The Role of the Obstetrician and Gynecologist,** Dr. M. Edward Davis, Joseph Bolivar DeLee Professor and chairman of the Department of Obstetrics and Gynecology, University of Chicago School of Medicine, and chief of service, Chicago Lying-In Hospital.

Noon—Luncheon for physicians and wives, Dr. John C. Smithson, Findlay, president of the Northwestern Ohio Medical Association, presiding.

### Afternoon Program

Moderator: Dr. C. H. Evans, Jr., Findlay.

**The Role of the Surgeon,** Dr. Louis P. River, clinical professor of surgery, Stritch Medical School

(Northwestern — Contd.)

of Loyola University; professor of surgery, Cook County Hospital Graduate School; attending surgeon, Oak Park and Cook County Hospitals.

**The Role of the Dermatologist,** Dr. Robert F. Dickey, director of the Department of Dermatology, The Geisinger Medical Center, Danville, Pa.

**Panel Discussion on Practical Medicine and Surgery for the Female Patient,** the foregoing speakers participating in the panel.

* * *

## Ohio Academy of General Practice Meets in Columbus, Oct. 18-20

The Ohio Academy of General Practice will hold its 12th annual Scientific Assembly in Columbus, Thursday-Saturday, October 18-20. Sessions will be in the Veterans Memorial Building unless otherwise designated. Sessions of the House of Delegates, Deshler Hilton Hotel, 9:00 a. m. October 17 and 12:00 noon, October 18.

### Thursday, October 18

Registration and visit of exhibits begins at 12 noon. Sessions start at 1:00 p. m.

**Useful Ophthalmoscopic Nuggets,** Dr. William H. Havener, Columbus.

**Acute External Otitis,** Dr. Irving L. Ochs, Annapolis, Maryland.

**Thyroid Function Tests,** Dr. George J. Hamwi, Columbus.

**What To Do About Children Who Are "Always Sick,"** Dr. John P. Riepenhoff, Columbus.

**GP's Approach to Emphysema,** Dr. Benjamin Schuster, Dayton.

**Is It an Innocent or Organic Murmur?** Dr. Joseph M. Ryan, Columbus.

Open house at 6:00 p. m., new OAGP headquarters office, 4075 N. High St., Columbus.

### Friday Morning, Oct. 19

Registration and visit of exhibits begins at 8:00 a. m.; Sessions at 9:00 a. m.

**Is This Chest Film Normal?** Dr. Jerome F. Wiot, Cincinnati.

**Five Practical Liver Function Tests,** Dr. Horace B. Davidson, Columbus.

**The Geriatric Stomach,** Dr. E. Clinton Texter, Jr., Chicago.

**How To Handle Arthritis in the Office,** Dr. Allen Hugh MacKenzie, Cleveland.

### Friday Afternoon

**Maternal Mortality Committee Studies**—Panel Discussion, Dr. R. A. Heilman, moderator; Drs. Anthony Ruppersberg, Jr., O. G. Austin, W. D. Beas-

(Continued on Next Page)

*(OAGP — Contd.)*

ley, K. R. Brandeberry, M. A. Davis, R. R. Maier, R. E. Swank and D. E. Thomas.

Uses of New Progestins, Dr. Nichols Vorys, Columbus.

Immediate Evaluation and Treatment of the Injured or Depressed Patient, Dr. James C. Appleton, Dayton.

Female Office Urology for the General Practitioner, Dr. Paul Schildt, Lakewood.

Recent Therapeutic Developments, Chauncey D. Leake, Ph. D., recently of Columbus.

Social hour and Annual Banquet at Deshler-Hilton Hotel.

Saturday Morning, Oct. 20

Registration and visit of exhibits begins at 8:00 a. m.; Sessions at 9:00.

The Commonest Disease — Functional Gastrointestinal Disorders, Dr. Charles H. Brown, Cleveland.

Family Relationships, Dr. William E. Mayer, Fort Sam Houston, Texas.

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## Sixth District PG Day Akron, October 24

The annual Sixth Councilor District Postgraduate Day will be held this year in Akron on Wednesday, October 24, with the Summit County Medical Society as host organization.

The program begins at 9:00 a. m.. Three simultaneous programs will be conducted in three different rooms during each period, giving physicians a choice of subject matter.

9:00 - 10:15 a. m. Period

Room I — Growth Problems — Pediatrician (Moderator), Dr. Samuel Spector, professor of pediatrics, Western Reserve University. Endocrinologists, Dr. E. Perry McCullough, Department of Endocrinology and Metabolism, Cleveland Clinic; and Dr. Olaf Pearson, associate professor of medicine, Western Reserve University.

Room II — Surgeon, Obstetrician and Internist Consultant on Obstetrical Emergencies — Obstetrician (Moderator), Dr. J. F. Hulka, assistant professor of obstetrics, University of Pittsburgh. Surgeon, Dr. Robert J. Izant, associate professor of surgery, Western Reserve University. Internist, Dr. Max Miller, associate professor of medicine, Western Reserve University.

Lecture—The Natural History of Cancer and Cancer Treatment — Internist, Dr. Michael J. Brennan, Henry Ford Hospital, Detroit.

10:45 a. m. - 12:00 noon Period

Room I — Peptic Ulcer — Internist (Moderator), Dr. Harvey J. Dworkin, Department of Medicine, Western Reserve University. Surgeon, Dr. William D. Holden, The Oliver H. Payne professor of surgery and director of the Department of Surgery, Western Reserve. Psychiatrist, Dr. Edward O. Harper, assistant dean, Western Reserve University School of Medicine.

Room II — Influence of the Prenatal Care on Newborn Pathology — Pediatrician (Moderator), Dr. Spector. Obstetrician, Dr. Hulka. Endocrinologist, Dr. Pearson.

Lecture — Surgeon, Dr. Izant (subject to be announced).

1:30 - 2:45 p. m. Period

Room I — Cancer Chemotherapy — Surgeon (Moderator), Dr. Holden. Gynecologist, Dr. Howard W. Jones, Jr., Department of Gynecology, Johns Hopkins Medical School, Baltimore. Internist, Dr. Brennan.

Room II — Pharmacologic Management of Everyday Psychiatric Problems — Psychiatrist (Moderator), Dr. Harper. Pharmacologist, J. George Bidder, Department of Pharmacy & Psychiatry,

*(Continued on Next Page)*

## Ohio State Offers Variety of Postgraduate Courses

The Ohio State University College of Medicine through its Center for Postgraduate Medical Education is offering a number of short courses for physicians during the school year. Physicians are invited to contact the center for details. Postgraduate courses offered in the near future are the following:

Diagnostic Methods in Cardiopulmonary Disease, September 13.

Contact Lens Seminar, September 17-18.

Functions of the Ego—a Postgraduate Seminar in Psychiatry, September 21.

Diagnosis and Treatment of Gastrointestinal Disease, September 21-22.

Graduate Course in Thoracic Diseases, September 28-29.

Pediatric Advances for General Practice, October 10.

Seventh Annual Session on Rheumatic Diseases, October 10.

Seminar on Medical Education (primarily for the faculty), October 10-11.

Rehabilitation of "Industrial Back," October 26-27.

Dept. of Urology Course, "The Neurologic Bladder," Nov. 16-17.

*(Sixth District — Contd.)*

*(Sixth District — Contd.)*

Western Reserve University School of Medicine. Psychiatrist, Dr. John I. Nurnberger, professor of psychiatry, Indiana University School of Medicine, Indianapolis.

Lecture — Internist, Dr. George G. Jackson, professor of medicine, University of Illinois, Chicago. (Subject to be announced.)

3:15 - 4:30 p. m. Period

Room I — Infections That Are Hard To Treat — Internist (Moderator), Dr. Jackson. Surgeon, Dr. Izant. Pediatrician, Dr. Spector.

Room II — Office Endocrinology — Endocrinologist (Moderator), Dr. McCullough. Gynecologist, Dr. Jones. Internist, Dr. Miller.

Lecture — Essence of Psychotherapy — Psychiatrist, Dr. Nurnberger.

* * *

## American Heart Association To Meet in Cleveland

Ohio will be host to an anticipated 4,000 physicians, medical students, professional health workers and other interested persons for the annual meeting and 35th scientific session of the American Heart Association in Cleveland Friday, October 26, through Sunday, October 28. Host organizations will be the Ohio State Heart Association and the Cleveland Area Heart Society.

The six sessions on clinical cardiology and 23 simultaneous scientific sessions are designed to meet the interests of specialists and physicians concerned with cardiovascular diseases, as well as clinical and basic science investigators.

A Friday morning attraction, sponsored by the American Heart Association's Council on Circulation, will be a discussion of "Buerger's Disease" by a group of Baltimore physicians: Dr. Robert D. Bloodwell, Dr. William M. Shelley, Dr. Ole E. Ottesen, Dr. Richard M. Goodman, and Dr. Victor A. McKusick.

This will be followed by a presentation on "Total Calf and Muscle 'Nutritive' Blood Flow During Tobacco Smoking" by Jay D. Coffman, M. D., and Stanley L. Javett, M. D., Boston.

Among other program highlights will be a symposium Friday afternoon on "Medical Management of Hypertension" with Colin T. Dollery, M. D., of London, England, as moderator, and featuring H. Mitchell Perry, Jr., M. D., St. Louis, on "Etiology and Natural History"; Richard E. Lee, M. D., New York City, "Diagnostic Tests"; Harriet P. Dustan, M. D., Cleveland, "To Treat or Not to Treat"; and Richard H. Lyons, M. D., Syracuse and New York, "Use and Abuse of Drugs."

Of special interest Saturday morning is an "Appraisal of Open Heart Surgery" featuring 10 presen-

### Metropolitan Areas and Medical Postgraduate Programs

The accompanying summary of postgraduate programs is presented in an effort to bring together sessions of particular district-wide interest. Many more postgraduate programs are available, particularly in the metropolitan areas. Physicians are invited to contact Academies of Medicine and Specialty Societies in these areas as well as the Medical Teaching Centers for lists of programs scheduled.

*(Heart Association — Contd).*

tations by physician teams from Cleveland, and other cities.

J. Scott Butterworth, M. D., New York University School of Medicine, and president of the American Heart Association, will give the annual presidential address Saturday afternoon, followed by the presentation of the Research Achievement Award. At the same session, George E. Miller, M. D., Chicago, will give the Lewis A. Connor Memorial Lecture on "Pride and Prejudice in Professional Education." As in the past, a series of cardiovascular conferences will be held Saturday evening.

Donald E. Gregg, M. D., Washington, D. C., will deliver the George E. Brown Memorial Lecture, "Physiology of Coronary Circulation," Sunday morning, followed by a symposium on "Pitfalls in Diagnosing Coronary Artery Disease" with Louis A. Katz, M. D., Chicago, as moderator.

The following physicians will participate: Dr. Herrman L. Blumgart, Boston, "Clinical Aspects"; Dr. George E. Busch, New Orleans, "Laboratory Aspects"; Dr. Charles E. Kossmann, New York City, "Electrocardiographic Aspects"; and Dr. E. N. Silber, Chicago, "Pitfalls in Integrating Clinical, Laboratory, and Electrocardiographic Findings."

James V. Warren, M. D., Columbus, president-elect of the American Heart Association, will chair the sixth and final session on clinical cardiology Sunday afternoon.

More than 50 Ohio physicians will participate in the three-day program.

Registration blanks and housing accommodation forms may be secured from any local heart association or by writing the Ohio State Heart Association, 131 E. State St., Columbus 15, Ohio.

* * *

## Ohio Psychiatric Association To Meet in Cincinnati

The Ohio Psychiatric Association has scheduled a program to be held at the Veterans Administration

*(Continued on Next Page)*

Hospital, Cincinnati, for Wednesday afternoon, October 24. A special evening meeting will follow.

The first half of the afternoon session will be a business meeting, and the second half will be devoted to a lecture entitled "Dream Work, 1962," to be given by Dr. Roy Whitman, associate professor in the Department of Psychiatry, University of Cincinnati College of Medicine.

The afternoon lecture at the V. A. Hospital by Dr. Whitman will be given at an open session beginning at 3:30 p. m. All interested members of the profession are invited.

In the evening, members of the OPA will be guests of the Cincinnati Society of Neurology and Psychiatry at the Emerson North Hospital, for a social hour, dinner and an evening speaker.

* * *

## Columbus Academy Offers Clinic Day Program, November 19

The Academy of Medicine of Columbus and Franklin County is offering a Clinic Day type program on Monday, November 19 at the Deshler Hilton Hotel in downtown Columbus. A social hour and dinner will precede the evening program. General chairman for the program is Dr. Jack C. Bass, Columbus.

Four specialty societies are participating in arranging the four phases of the scientific program. They are:

The Columbus Eye, Ear, Nose and Throat Society,
The Columbus Society of Internal Medicine,
The Columbus OB-GYN Society, and
The Central Ohio Pediatric Society.

## Continuing Education Courses Listed in AMA Journal

An excellent list of Continuing Education Courses for Physicians was published in the August 11 issue of *The Journal of the American Medical Association,* beginning on page 485. The list contains courses scheduled to August 31, 1963.

The listing includes 1,146 continuing education courses, offered by 208 institutions in 38 states and the District of Columbia. Many of the courses are in Ohio. Listing is under 38 fields of medicine.

## Fall Influenza Vaccination Recommended by PHS

The Surgeon General of the Public Health Service, upon the recommendation of the Advisory Committee on Influenza, has urged early fall vaccination of the susceptible population against influenza. As in previous years, the susceptible population includes the aged, the chronically ill, and pregnant women. This year the susceptible population has been expanded to include those over 45 years of age.

## Beware of the Telephone Book Ripper!

"Ninety-five pound weaklings, arise! You, too, can shred telephone books and sweep your friends off their feet with one finger. All it takes, according to Arthur Blackmer, Author, Authority and Athlete, who does it every day, is slow chewing, clean living and, oh yes, his very own Energy Instant Broth (one month's supply, $5.00).

"Health fads come and go, and Blackmer's seems to be no more insidious than any other, though we're not altogether convinced that his claims for the regimen would stand up in court. Where Arthur Blackmer shocks the conscience, is in taking advantage of service groups who invite a speaker and get a pitchman.

"Offering himself as a luncheon speaker before such clubs as the Rotarians, Kiwanis, etc., Blackmer promises radiant health, superior strength, abundant energy and lasting happiness. He tears the telephone book, drives a spike with his bare hands and lifts a man off the floor with his teeth. Then, just when the guests have begun to feel entitled to at least a hundred years of high living, he goes into his pitch. It seems that Mr. Blackmer will sell you his full line of products and a health course. We've seen a sample of the latter and we can't help feeling that anyone with a grade school education already knows all Blackmer has to tell him.

"Far be it from us to decry any powdered soups that can instill 'romantic energy' at eighty-five and prolong happy lives to the century mark, but we must warn that Mr. Blackmer's products have not always been delivered as promised and he was unwilling to state where they could be purchased locally. It may be that you'll have to struggle along on your regular diet." — *Columbus Better Business Bureau Beacon.*

## American Public Health Association To Meet at Miami Beach

The 90th annual meeting of the American Public Health Association will be held at the Fontainebleau Hotel, Miami Beach, Florida, October 15-19. The organization which numbers its membership at some 13,000 is expecting 6,000 to attend the meeting. Meeting with the Association will be more than 60 related organizations. Further information may be obtained from Berwyn F. Mattison, M. D., Executive Director, 1790 Broadway, New York 17, N. Y.

A three-year research project on ways to prevent and treat diseases of the liver has been launched at the University of Cincinnati Medical Center with a $62,717 grant from the National Institutes of Health. The first year of study will be under the direction of Dr. Leon Schiff, professor of medicine and director of the Gastric Laboratory at General Hospital.

## Books and Pamphlets To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room or for his personal information.

* * *

**Nursing Education Programs Today.** This booklet describes the five types of educational programs current in nursing—practical nursing, associate degree, diploma, bachelors degree and graduate education in professional nursing—and has been issued by the National League for Nursing, New York. Outlined in the statemeint are student and admission requirements for each type of program, faculty responsibilities, curriculum offerings, and the nursing roles for which each program prepares its graduates. Single copies free upon request to the National League for Nursing, 10 Columbus Circle, New York 19, N. Y. Quantities are available at these rates: 2 to 99 copies, 20¢ each; 100 to 499 copies, 15¢ each.

* * *

**Current Medical Terminology:** This paperback, pocketsize guide to the preferred medical terms of all important diseases is now available from the AMA. The book provides definitions, known or possible causes, and most characteristic disturbances and findings of 2000 diseases and conditions. Copies of the book may be ordered from AMA's Circulation and Records Dept., 535 N. Dearborn, Chicago 10, Illinois. Price is $2.

* * *

**Booklet-Type International Certificates of Vaccination.** (PHS 731, Rev. 6-61). Booklet has two sections. The first contains the International Certificates of Vaccination as described in the International Sanitary Regulations, with name of physician added. The latter assists the health authority to quickly identify the immunizing physician before applying the "approved stamp" to either the smallpox or cholera vaccination certificate. The second section contains information concerning the personal health history of the traveler and instructions for him and his physician. Write Superintendent of Documents, Government Printing Office, Washington 25, D. C. Ten cents per copy.

* * *

**AMA 1962 Film Catalog:** The 1962 catalog of the film library of the American Medical Association is now available. The catalog contains information about 173 films for professional audiences and 82 films which can be used by physicians addressing lay groups. Catalogs are available from the Dept. of Medical Motion Pictures, AMA, 535 N. Dearborn, Chicago 10, Illinois.

## Association Announces Recipient Of Rural Medical Scholarship

Wesley W. Hiser, 21, of Ludlow Falls, O., Route 1, Miami County, is the 1962 recipient of the Ohio State Medical Association's Rural Medical Scholarship. The scholarship consists of $500 a year for four years of medical school.

Selection of Hiser, who will enter The Ohio State University College of Medicine in September, was announced by Dr. George J. Hamwi, of Columbus, Medical Association President. Hiser completed his pre-medical work at Ohio State in March.



Wesley W. Hiser

A son of Mr. and Mrs. John H. Hiser, who reside on a 73-acre farm, the scholarship winner gained first place in the annual selection on the basis of his high ratings in the six categories in which applicants are judged: character and integrity, native intelligence, mature personality, interest in rural activities and organizations, leadership and scholastic ability.

He has been active in 4-H Club work, Future Farmers of America, church young people's groups, sports, and school programs. He earned 100 per cent of his pre-medical school expenses. Hiser plans to practice medicine in a rural area upon completion of his medical education.

The Rural Medical Scholarship, administered through the Association's Committee on Rural Health, was launched 14 years ago to stimulate among young men and women in Ohio's non-metropolitan areas interest in the study of medicine, in the belief that they are more likely to engage in medical practice in rural communities. The scholarship is a part of the Association's continuous activities to interest physicians and medical students in rural practice.

Other such activities include annual programs for medical students to point out the advantages of rural practice, an annual preceptorship program whereby medical students spend two weeks with a rural general practitioner, and the OSMA's Physicians' Placement Service. This service assists physicians in finding locations for medical practice, at the same time encouraging them to consider rural areas.

The Scholarship Committee consists of J. Martin Byers, M. D., Greenfield, Chairman, and Drs. Jasper M. Hedges, Circleville, Luther W. High, Millersburg, and Kenneth W. Taylor, Pickerington.

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Dr. Frank H. Mayfield, Cincinnati, former president of the Ohio State Medical Association, is the new chairman of the American Board of Neurological Surgery.

# Celebrezze Stirs Up Ruckus . . .

## New HEW Secretary Draws Fire of Officials After Statement Regarding Kerr-Mills Situation in Ohio

WHEN Anthony J. Celebrezze, new secretary of Health, Education and Welfare, commented at his first news conference on August 8 that Ohio needs the Kerr-Mills law to give medical aid to the elderly, he stirred up quite a ruckus.

### Cleveland Press Reports

Here's the way the *Cleveland Press* reported the situation:

"Is Ohio backward in its care of the indigent sick, people who can't afford proper medical care? And if it is, who's to blame?

"In his very first press conference as U. S. Secretary of Health, Education and Welfare, Anthony J. Celebrezze stirred some angry reaction back home. He said the Ohio Legislature had failed to adopt legislation so the state could use the Kerr-Mills bill.

"That bill gives states federal funds to help pay for medical care of the needy who are 65 and over.

" 'There's a great dispute now in Cleveland over who will pay for the care of the indigent sick,' said the ex-mayor.

"Cleveland and Ohio officials roared in response.

" 'The problem here is that we have had a mayor trying to dodge the city's responsibility to pay for the care of its needy sick,' said Thomas Griffiths, executive secretary of the Cleveland hospital council. He denied the Legislature was to blame for the problem.

"Robert Taft, state representative and Republican candidate for congressman-at-large, handed the blame back to the Democrats (like Celebrezze). Ohio Welfare Director Mary Gorman told legislators the state was not interested in the Kerr-Mills Act, Taft said. 'I don't think Celebrezze is giving a true picture.'

"Ohio has a better health program for the elderly than states using Kerr-Mills, declared Tom Weiler, head of Aid for Aged. Ohio's help, however, is dependent upon the recipient giving the state a lien on his property, collectible at death or sale.

"Celebrezze, incidentally, came out flatly for President Kennedy's medicare proposal, financed by Social Security collections."

The five-time mayor of Cleveland, who was sworn in only one week earlier, was quoted in the *Columbus Dispatch* as having stated if cities in Ohio can't get help from the state then they must turn to the Federal government for financial assistance. Celebrezze, the *Dispatch* said, further stated that the Ohio Legislature's failure to adopt the federal law placed in jeopardy the proper care of the indigent sick.

### DiSalle's Opinion

In reply to this, Governor Michael V. DiSalle was quoted in the press as having said that he never advocated before the Legislature that Ohio adopt features of the Federal act although it was prepared by the lawmakers in a bill sponsored by a GOP member. The bill died in committee with the adjournment of the legislature. DiSalle added that he would be "very happy" to advocate the adoption of the law "if the (legislative) leaders would approve it and furnish the $30 million," the estimated cost of the state's share for two years.

### Mrs. Gorman Quoted

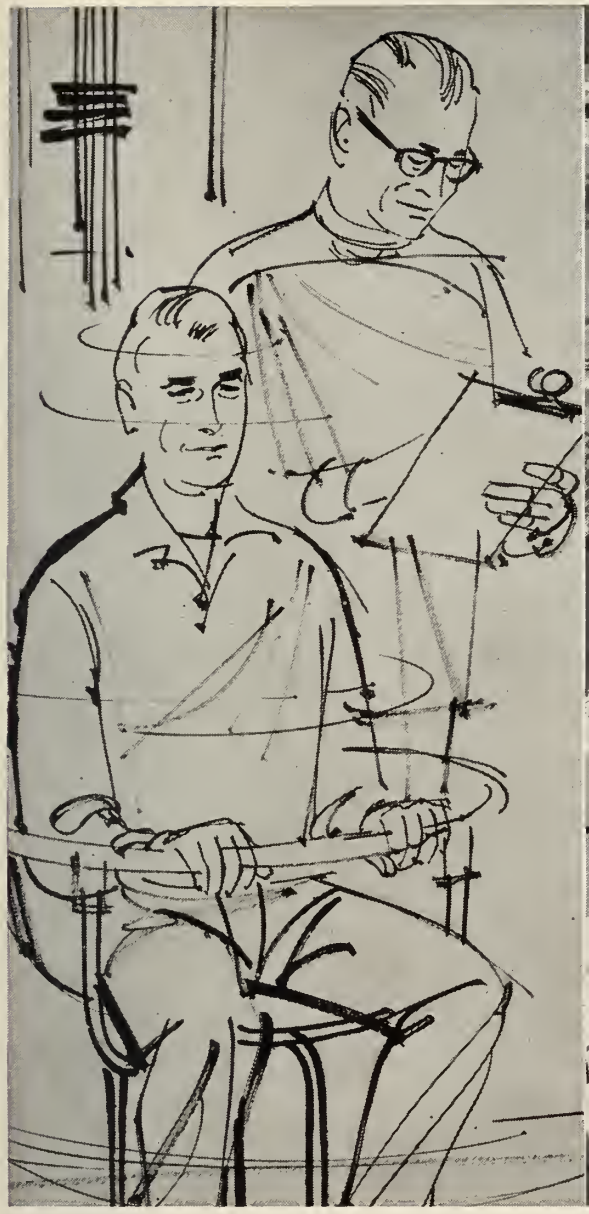
Ohio Welfare Director, Mrs. Mary Gorman, advised the newspapers that she had told Republican legislative leaders that Ohio had "a good medical care program" for the aged who were willing to meet state requirements. Mrs. Gorman added that under Ohio's present Aid for the Aged program the same level of payment has been achieved that is available under Kerr-Mills. "Many states had no health programs for the elderly," she said. "And Kerr-Mills is a big step forward for them."

Under the present Ohio Aid for the Aged program, a lien is placed against the property of the elderly person and a residency of three years out of the preceding nine must be established. Such liens, collectible from the estate after death, and residency requirements are prohibited under Kerr-Mills by any state receiving 50-50 matching funds from the federal government. However, Ohio presently receives 57 per cent matching funds under its regular aid for the aged program.

### Taft's Views

Taft was quoted elsewhere as hazarding a guess that the DiSalle state administration, along with other Democratic state administrations across the country, was against the Kerr-Mills plan because the Kennedy Administration was emphasizing its program to put medical care for the aged indigent sick under Social Security. "They didn't want to build up Kerr-Mills," commented Taft.

The Ohio health care program for aged was explained in the June 15 issue of the *OSMAgram* and in detail in the July issue of *The Ohio State Medical Journal,* pages 844-845.



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SEARLE

Research in the Service of Medicine

# Podiatry (Chiropody) in Ohio...

## Factual Data Are Presented To Acquaint Physicians with This Branch of Practice

THE following information regarding the practice of podiatry in Ohio is being published at the request of the Ohio Podiatry Association. The purpose is to inform physicians about the nature and status of podiatry, especially in Ohio.

Podiatry has been a recognized profession in Europe since the Middle Ages — charged with the diagnosis and correction or alleviation of foot ailments. It was first practiced in America at Boston 125 years ago. There are now 8,000 Podiatrists in the United States.

Under Ohio Law, (Sec. 4731.51) "The practice of chiropody (podiatry) consists of the treatment of ailments of hand or foot, nonsystemic in character, and the treatment of muscles and tendons of the lower leg governing the functions of the foot. It shall also include the making of molds or casts of the foot or any part thereof for the purpose of fitting or prescribing appliances, devices, or shoes for the correction or relief of foot ailments."

A certificate authorizing the practice of podiatry in Ohio permits necessary operative procedures and other treatments for nonsystemic ailments of the hand or foot. Where the use of general anesthetics is necessary a physician must be in attendance. Podiatrists are permitted to use local antiseptic preparations and local anesthetics. They may use analgesics and antibiotics and may prescribe these items when necessary for the treatment of non-systemic situations. X-ray may be used for diagnostic but not for therapeutic purposes.

The Ohio State Medical Board confers certificates authorizing the practice of Podiatry on individuals who have earned the degree "Doctor of Surgical Chiropody" (Podiatry) at a recognized College of Chiropody, (Podiatry) and have passed the Board's podiatry and Basic Science examinations.

Before the student can enter one of the five accredited Colleges of Podiatry in the U.S.A. he must have successfully completed at least one year of premedical studies. In actual practice, many applicants have 2-4 years college preparation.

Each College of Podiatry requires four years of professional training, including courses in anatomy, chemistry, embryology, histology, materia medica, physiology, preventive, bacteriology, orthopedics, pathology, podiatry, neurology, pharmacy, surgery, roentgenology, circulatory disease, dermatology, toxicology, anaesthesia, internal medicine, psychiatry and clinical practice.

All studies related to medical or surgical subjects are taught in departments headed by doctors of medicine.

The licenses of Ohio podiatrists must be renewed annually. Applicants for renewal must give evidence they have taken a Medical Board approved, two-day postgraduate course during the preceding 12 months.

### Institutions Recognize Services of Podiatrists

A commissioned Doctor of Podiatry heads the podiatry department at the Walter Reed Army Medical Center at Bethesda, Maryland. Twelve or fifteen Podiatrists have been commissioned in the armed forces since the position was created.

Podiatrists are engaged in teaching at the Ohio State University Medical Center Diabetic Clinic and several other medical facilities in our state. Many are on the staffs of Ohio hospitals, clinics and state institutions.

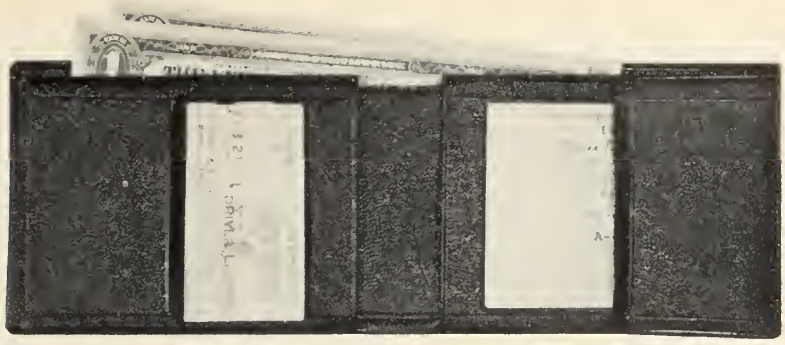
According to officials of the Ohio Podiatry Association, members of the Association are constantly being urged to be fully aware of the need for complete cooperation with the physician in order to serve the best interests of each patient and to recognize a profound responsibility not to exceed the limits of their practice.

### Chiropody Changed to Podiatry

It should be noted that the foot doctors in Ohio are to be known henceforth as "podiatrists" and the state association as the Ohio Podiatry Association instead of the traditional and often confused term, "chiropodists." The change was made May 24, 1962.

Podiatrists hope to eliminate confusion with other professions using the prefix "chiro," and the inference that podiatry practice is a "cult" instead of the use of accepted medical and surgical procedures on the foot.

Although "chiro" means "hand" and Ohio law permits the podiatrist to work on the hand it is the exception rather than the rule that treatment of the hand is performed by the podiatrist.



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In Our Opinion

# Your Candidate Alone Can't Win; With Your Help, He Can

THE President says he wants to make medicare, the King - Anderson bill, the Kennedy plan, or what-have-you, in the line of compulsory health insurance, an issue in the coming Congressional elections.

That will be okay so far as the overwhelming majority of Ohio physicians are concerned, in our opinion. That being the case, it is imperative that each physician, members of his family and all other folks in his community who believe the Kennedy medicare plan wrong, start politicking right now. They know which Congressmen have been friends or foes. If they don't, there are easy ways of finding out.

"Candidates don't win elections," Raymond Moley once wrote, and he added: "Organized personal effort at the voter level and vigorous man-to-man persuasion are decisive. Elections are not won on the stump or on the TV screen. They are won at the front door of voters and at the roadside in the country and at the workbench in the factory. For the women, it should be added that elections are won also when they drop in on their neighbors and chat. It is a well known fact that personal contacts, and personal contacts alone, are the final means of delivering the vote."

Are you willing to accept Kennedy's challenge? Are you prepared to roll up your sleeves and go to work for the candidate who meets your specifications; help to rally many others to do likewise?

Are you ready to take part in "register and vote" campaigns aimed at getting sound conservative citizens qualified to vote and to the polls on November 6? The deadline for qualifying in registration areas and for those who have to re-register for some other reason, is September 26.

Your favorite candidate alone can't win. He needs your help and the help of scads of people like you.

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### ANOTHER SAMPLE OF GOOD P. R.

The Cincinnati Academy of Medicine has asked all of its members to actively support the Cincinnati public school bond issue and tax levy to be voted on in November and to get other citizens to do so. It has supplied all members with a pamphlet designed to acquaint citizens with the needs, problems and accomplishments of the city's schools, suggesting that the copy be placed in the physician's waiting room for patients to read.

This is good public relations in action.

This shows how physicians as citizens can get behind community projects other than those confined to the field of medicine-health.

It refutes again the charge that doctors are not interested in general community welfare and projects. Those who are informed know that physicians are concerned about community activities generally. Nevertheless, it behooves the profession to prove this as is being done by the Cincinnati Academy.

### SOUND ALTERNATIVES TO KENNEDY PLAN AVAILABLE

The Senate's rejection of King-Anderson type legislation is not a rejection of interest and responsibility on the part of Congress or the medical profession — in fact not on the part of the public generally — in assisting those aged persons who are in need of help in meeting the costs of health services. It simply was a refusal to make it a Social Security benefit regardless of need.

Ways already exist under the public assistance programs to meet this problem if the existing programs — Ohio's Division of Aid for the Aged Health Care Program, for example — are properly financed

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*
*— Justice Robert H. Jackson in AAA Supreme Court Case, 1942*

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| Zinc (as Zinc Betaine Citrate) | 1.25 mg. |
| Magnesium (as Magnesium Betaine Citrate) | 6.0 mg. |
| Vitamin B-1 | 1.5 mg. |
| Vitamin B-2 | 1.2 mg. |
| Vitamin B-12 | 6.0 mcg. |
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| Panthenol | 10 mg. |

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by the state or Federal government, or both. If you haven't read the article on the Ohio program which appeared in the July issue of *The Ohio State Medical Journal*, pages 844-845, do so. It is enlightening in the light of the false charges which have been made that Ohio hasn't a program to help the needy aged sick.

Those who cry that the public assistance approach requires a "means test" are on untenable ground. Public housing is available only to those with income below a certain amount. Veterans must prove need before they can get free care in a VA hospital for non-service connected disability. The Social Security system itself requires proof of income for all under 72 before they can get its benefits. Other good examples could be cited.

Those who shout that there are no sound alternatives to the Kennedy compulsory proposal are off base. The public assistance program is available to those who are needy. Those who with means always can take advantage of the voluntary medical and hospital plans.

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## CARDINAL RULES ON PRESCRIBING

Physicians can keep out of trouble and misunderstandings with patients and druggists if they will follow a few cardinal rules when prescribing, namely:

Write so the prescription can be read.

Give the complete name and address of the patient.

Indicate whether the patient an adult or child —exact age of child preferably.

Give specific directions for use.

Try to accurately estimate the amount of medication which the patient will need and make the prescription accordingly.

Specify whether or not the prescription should be refilled; if so, how often.

Mention the possible side effects or symptoms that might indicate patient should stop taking the medicine.

Keep a record of all prescriptions.

Double check every telephone prescription by having druggist read it back.

Read over every written prescription, checking for possible errors.

The above are based on an article which appeared in *Medical Economics*.

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## WHY OPERATING COSTS OF HOSPITALS ARE MORE

It cost American hospitals nearly $1 billion more to operate in 1961 than in 1960, the American Hospital Association reports, the cost being $9,387,242,000 in 1961, compared with $8,420,986,000 in 1960, with nearly two-thirds of the costs in both years going for payroll; $6.2 billion in 1961; $5.6 billion in 1960.

Hospitals also cared for a record number of patients — 25,474,370 — an increase of nearly half a million over 1960.

Average cost to the hospital per patient day rose in all categories of hospitals in 1961. In the nonfederal short-term general hospitals (which admit 91.7 per cent of all patients), the cost was $34.98, an increase of $2.75 over the $32.23 of 1960. This average included voluntary hospitals, $36.04; proprietary, $33.29 and state and local governmental, $32.27. In the long-term nonfederal hospitals the average cost in the psychiatric institutions was $5.53; tuberculosis, $14.72; long-term general, $14.49. The federal hospital average was $23.34.

Commenting on the increasing costs, Edwin L. Crosby, M. D., director of the Association, said: "Most of the increase results from rising labor costs, as salaries rise generally and as more highly skilled employees are needed to provide today's highly specialized care. Other factors influencing the rise are increasing research, education of health personnel, and rising equipment costs. Still another factor is the continually increasing number of visits to hospitals by outpatients, who are not counted in the number of inpatient admissions, but whose care adds to the expense of operating the hospital."

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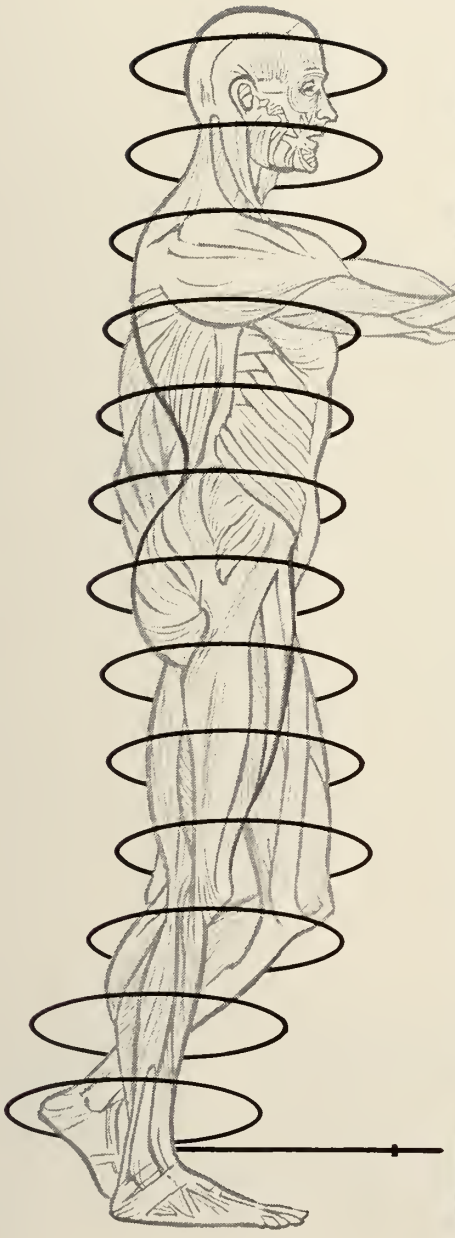
## MANY CAN'T BREAK EVEN ON SOCIAL SECURITY

Robert L. Mullins, Ohio superintendent of insurance, in a public statement, contended that defeat of the King-Anderson compulsory health insurance measure will work a hardship on younger Blue Cross subscribers who "will have to carry the load for aged subscribers who are more likely to need medical aid."

Mr. Mullins apparently overlooked, or did not want to mention, the fact that Social Security taxes are so high now that an average worker under 40, according to the *Wall Street Journal*, who enters the plan now has little prospect of receiving benefits worth even as much as the taxes paid; not to mention that the more inflation we have the less his benefits will buy. Obviously, tacking health care onto Social Security will make the SS take that much larger and pinch the younger and middle class folks that much harder.

Social Security is getting to the point where the costs are exorbitant. Even without medical care, the tax rates are slated to increase nearly 50 per cent in the next five years. That won't be the end, either, as there will be constant pressures for more benefits.

What if the younger Blue Cross subscriber does have to help pay for Blue Cross coverage for the oldsters? In the end, the toll probably won't be as great as that exacted by Social Security; also, there's a minimum of government regimentation in the voluntary plan.



Now available. After 3½ years of intensive clinical testing at one of the country's leading research centers,* Hemathermatrol announces a major

# breakthrough in hypothermia

The system is called TEMTROL. Through a unique computer system it can provide a degree of accuracy, speed and versatility in achieving clinical hypothermia never before possible. Here is a brief on its capabilities. *VERSATILE*—A variety of ancillary attachments permit one compact unit to produce all the requirements for gastric hypothermia, hypothermic amputation, differential cerebral hypothermia, extra-corporeal temperature control and other uses. *ACCURATE*—Exacting electronic control not only eliminates temperature drifts but will automatically maintain total body temperature, even on adults, within plus-minus 0.5° F of desired temperature. *FAST*—Under normal conditions the unit will reduce the temperature of a 70 kilo patient 10° F in 1½ hours. *COMPLETELY AUTOMATIC*—TEMTROL follows the patient's temperature by anticipating and computing rate of change to maintain temperature at predetermined level.

We invite you to write for literature describing the TEMTROL system in detail and offering an unusual 21 day trial in your hospital or clinic.

*Clinical data on request

*The Union of Engineering and Medical Sciences*

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**Witness a demonstration of TEMTROL at our Booth 81 during the A. S. A. Annual Meeting, October 22 - 26, Statler Hilton Hotel, New York City.**

Out of the Blue

# Why Obstetrical Indemnity Must Be Kept Low

By R. DEAN DOOLEY, M.D.
Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

ONE segment of medical practice which has been the subject of frequent discussions is obstetrics. The question is frequently asked why our obstetrical indemnification is not more realistic. Before the question can be answered we must explore the function of insurance. While health insurance has its peculiar qualities, it is still insurance and to be sound must conform to insurance principles. It is fundamental that it provide realistic financial assistance to protect the insured against the unpredictable and unexpected costs of health care.

One of the first criteria of a sound insurance program is that predictable or controllable events are not subject to insurance. To ignore this principle is to invite temptations, malefactions, and misuse.

By no standards does indemnification of obstetrics conform to this basic principle. The very object of the marital arrangement is to beget children so, by and large, we are insuring an event which is planned, desired, and most likely to occur.

## Prudent Planning

Actually, the average couple can conveniently meet the expense of obstetrical services more economically by prudent planning than through insurance devices. Most voluntary plans included a token of obstetrical coverage early in the development of their programs and it is difficult to eliminate coverage once it is instituted.

It is possible our future contracts will carry increased obstetrical benefits. Currently we have two contracts which provide additional obstetrical benefits on a group basis for an additional premium of 25¢ monthly per family contract for each $25.00 increase in benefits. Several groups have taken advantage of this and now carry higher obstetrical indemnification.

## Job Is Difficult

We have found that realistic indemnification of obstetrical services is difficult because of the extreme variation in charges. None of the specialty groups in my experience is subject to such wide differences in charges. Certainly to satisfactorily indemnify obstetrical services we will raise the expense of that care in many sections of the state and still underpay in many other areas. The token payment we now employ seems to be the best answer. It is obvious that other related professional services not now subject to indemnification merit consideration in our future planning.



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MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

# OMI Campaign Report . . .

## Two Out of Three Groups Contacted Convert to More Adequate Coverage: Continued Cooperation Is Asked

OFFICERS of Ohio Medical Indemnity, in a message of physicians of Ohio, reported continuing success in the campaign to up-grade the older contracts still held by many persons in the State in favor of the more adequate medical-surgical coverage in the "Preferred" and "Major" plans.

So far, two out of three groups contacted and informed have converted to the more extensive coverage, but there are still many of the old-fashioned contracts, some dating back to 1945, and physicians are urged to use their influence with patients toward obtaining the more adequate coverage.

### Letter to Physicians

In a letter to physicians of Ohio, Dr. H. M. Clodfelter, OMI president, wrote as follows:

"Dear Doctor::

"Thank You for Helping!

"We are happy to report that our present promotional campaign to up-grade the medical-surgical coverage of our "Group Plan" members is meeting with great success. So far, two out of three groups contacted and informed have already converted to the more adequate protection provided by our 'Preferred' and 'Major' plans.

"However, many groups and individuals are still deliberating and have not acted. Because your influence is (and has been) such a major factor in the success of our present campaign, we ask you to continue to help us by encouraging your patients to take advantage of the better medical-surgical protection now provided by Ohio Medical Indemnity, Inc.

"To help you do this, we have enclosed some more "Group" folders, which will tell the complete story to your patients. We hope you will place these in in the Blue Shield Poster we provided at the start of the campaign, or in some other prominent place in your waiting room.

"Your Help Is Most Appreciated — Thank You!"

Sincerely,

H. M. Clodfelter, M. D., President, O. M. I.

### Folders Available

The folders referred to in the letter are entitled "Blunt Talk, To All Blue Shield Subscribers of Ohio Medical Indemnity, Inc." and are available for distribution through physicians waiting rooms or by other means.

### 65-and-Over Program

In another campaign to enroll additional persons in the 65-and-over age group, OMI reported that 20,000 persons had been added in this category within the two-week period when enrollment was opened. This is the second effort within two years by Ohio Medical Indemnity to provide medical-surgical coverage for persons in this age group, in addition to senior citizens covered through groups.

---

## Super Computing System Planned for University of Cincinnati

Plans are under way for installation by September 1963 of an IBM 7040 computer system which would make the University of Cincinnati Medical Center one of the nation's three largest medical computing centers. The University of California at Los Angeles has such a system and Tulane University, New Orleans, is installing one.

Cincinnati University has been granted $686,000 by the National Institutes of Health to maintain its biometrics laboratory (biomedical computing center) for five years and to purchase the giant IBM 7040. An IBM 1401 also will be installed. The smaller computer will speed up processing of information for the super-rapid operation of the 7040.

Dr. Theodor D. Sterling, associate professor of biostatistics is in charge of the computing center. Dr. Samuel A. Trufant, associate dean of the College of Medicine and associate professor of neurology, heads a committee to supervise the expanded operations of the center, assisted by Dr. Robert A. Kehoe, director of the University's Kettering Laboratory.

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The 1962 edition of "A List of Current Health Insurance Books" by the Health Insurance Institute is now available from the HII office, 488 Madison Avenue, New York 22.

The booklet also lists organizations with a relationship to health and the financing of medical care, periodicals in the field of health insurance, and other insurance booklists.

## Saskatchewan Doctors Accept Compromise Proposal

On July 23, the Saskatchewan physicians and provincial government reached an agreement ending the doctors' 23 day protest against a compulsory, government-controlled medical care plan.

When the amended plan comes into force, both patients and doctors will have four choices open to them. The patient may choose:

- A doctor who is enrolled with the plan for direct payment. His doctor will bill the commission or otherwise be paid by it, and there will be no further charges.
- To enroll with a private health insurance agency to which he will pay an enrollment fee, and, if he chooses, a further premium for additional benefits; he may then choose a doctor who has a service contract with the agency, the doctor will send the bill to the agency and there will be no further charge.
- Not to enroll with a voluntary agency, and to choose a doctor not enrolled with the medicare plan. His doctor will bill him at his discretion and the patient will be reimbursed by the commission up to 85 per cent of the college's minimum fee schedule.
- To go to a doctor who has decided to practice entirely for private fees. The patient will then pay the full fee himself, as in ordinary private practice, and will have no claim on the commission.

The doctor also may choose to:

- Enroll with the commission for a minimum set period of time, and be paid directly by fee-for-service, by retainer and a smaller fee-for-service, or fixed remuneration.
- Practice partly, largely, or entirely in association with one or more voluntary agencies, being reimbursed by the agency for 85 per cent of the minimum fee schedule, the agency receiving the same sum from the commission.
- Practice outside the act, yet bill some or all patients in itemized form so that they may pay him and collect from the commission.
- Practice entirely for private fees if his patients agree to make no use of the medicare scheme.

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### Berry Plan Recruiting Begun By Defense Department

In late July every male hospital intern who is obligated for military duty received his guidebook and application form for participation in the Berry Plan. In executing this form, he will indicate whether he wishes draft-deferment while taking residency training, his choice of military service and how soon after completion of internship he desires to begin active duty. October 1 is the deadline for return of the statement of preference (SD Form 249).

# Coming Meetings . . .

(See also Schedule of Postgraduate Courses in Ohio, beginning on page 1040.)

**American College of Surgeons,** Clinical Congress, Atlantic City, October 15 - 19.

**American Medical Association,** Clinical Meeting, Los Angeles, Calif., November 25 - 28.

**Ohio State Medical Association,** Annual Meeting, Cleveland, week of May 12, 1963.

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## Courses for Chest Physicians Scheduled for Fall Season

The American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill., is offering its 15th Annual Postgraduate Course entitled "Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs," at the Warwick Hotel, Philadelphia, Pa., September 17-21.

Other postgraduate courses offered in the near future include the following:

"Clinical Cardiopulmonary Physiology," Chicago, October 22-26, Knickerbocker Hotel.

"Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs," New York City, November 12-16, Barbizon-Plaza Hotel.

"Occupational Diseases of the Heart and Lungs," Detroit, December 3-7, Statler-Hilton Hotel.

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### Expert Committee Will Study Impact of Smoking

Plans for the establishment of an expert committee to study the impact of smoking upon health were made late in July when Surgeon General Luther L. Terry of the Public Health Service met with representatives of several Federal agencies, non-governmental professional groups, health organizations and the tobacco industry.

Represented at the meeting were the American Cancer Society, the American College of Chest Surgeons, American Heart Association, American Medical Association, The Tobacco Institute, Inc., Food and Drug Administration, National Tuberculosis Association, Federal Trade Commission, and the Office of Science and Technology of the Office of the President.

According to Dr. Terry, the study will be concerned not only with tobacco but all other factors which may be involved such as air pollution, automobile exhausts, etc. It is expected to get underway by mid-September, with the first phase completed in approximately six months.

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Dr. William W. David, Westerville, has been elected president of the Franklin County Heart Council. Dr. Davis is the medical director of North American Aviation, Columbus.



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*is indicated*

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INDICATIONS: **Impotence in male.**

AVERAGE DOSE: One tablet three times daily.

AVAILABLE: Bottles of 100 and 500 at your pharmacy.

CAUTION: Not to be used when testosterone is contra-indicated. Federal law prohibits dispensing without prescription.

1. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No. 2, February, 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

***Write for samples and literature...***

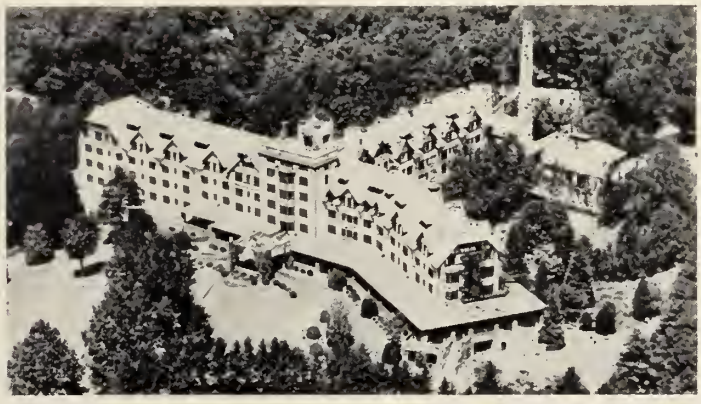
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## Red Cross Has Limited Supply of Vaccinia Immune Globulin

One of the services of the Red Cross Blood Program is that of supplying vaccinia immune globulin (VIG) to physicians for treatment of rare conditions. A communication from the American National Red Cross states that the pamphlet on this subject has been revised slightly and that some of the names and addresses of contact persons have changed. Revised pamphlets are available from local Red Cross offices.

Following is a summary of the information contained in the revised pamphlet with names of contact persons in Ohio and neighboring areas:

The vaccinia immune globulin program has been established by the Red Cross in cooperation with the U. S. Armed Forces as another regular service of the Red Cross Blood Program. The rare blood product contains a high titer of antibodies effective in arresting abnormal infections with vaccinia virus.

"Any physician who feels that VIG might be required for a patient," the pamphlet states, "should telephone the nearest consultant, whose name, address and telephone number may be obtained from the nearest Red Cross regional blood center. If it is agreed that the condition of the patient requires treatment with VIG, the consultant will authorize its shipment from the nearest regional blood center."

A representative of the Red Cross recommended that the physician make a person-to-person call to the director of the regional center in his area. Regional centers to which Ohio physicians would call are the following:

Columbus Regional Red Cross Blood Center, 812 E. Broad St., Columbus 5; CL 3-5541; Dr. Charlotte Winnemore, director.

Cleveland Regional Red Cross Blood Center, 1227 Prospect Ave., Cleveland 15; SUperior 1-1800; Dr. Louise Keating, director.

Toledo Regional Red Cross Blood Center, 2215 Collingwood Blvd., Toledo; CHerry 3-5146; Dr. Hoyt B. Meader, director.

Fort Wayne Regional Red Cross Blood Center, 406 W. Berry St., Fort Wayne, Ind., EAstbrook 3025; Dr. Harry C. Harvey, director.

Huntington Regional Red Cross Blood Center, 724 Tenth Ave., Huntington 1, W. Va.; JAckson 2-0328; Dr. F. C. Hodges, director.

VIG is effective in preventing the disease or diminishing the severity of smallpox in individuals who have had close contact with a case of smallpox. It is also highly effective in the treatment of the rare complications from vaccination, the most frequent of which is accidental inoculation into the eye; or accidental inoculation from the vaccination of one child to an eczema on another child.

It is *not* indicated in (1) cases which are not vac-


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CONTINUING EDUCATION COURSES
STARTING DATES — FALL, 1962

Surgical Technic, Two Weeks, November 5
Surgery of Colon & Rectum, One Week, November 26
Surgery of Stomach & Duodenum, One Week, Sept. 24
Vaginal Approach to Pelvic Surgery, One Week, Oct. 1
Gynecology, Office & Operative, Two Weeks, November 5
Obstetrics, General & Surgical, Two Weeks, October 8
Urology, Two Weeks, October 29
Proctoscopy & Sigmoidoscopy, One Week, October 29
General Practice Review, One Week, October 8
Gallbladder Surgery, 3 Days, October 8
Surgery of Hernia, 3 Days, October 11
Basic Electrocardiography, One Week, October 1
Advances in Medicine, One Week, October 15
Advances in Surgery, One Week, December 10
Blood Vessel Surgery, One Week, October 22
Board of Surgery Review, Part I, Two Weeks, Nov. 5
Board of Surgery Review, Part II, Two Weeks, Nov. 26
Clinical Uses of Radioisotopes, Two Weeks, October 1
Treatment of Varicose Veins, One Week, October 29

*Information concerning numerous other continuation courses available upon request.*

TEACHING FACULTY
ATTENDING STAFF OF COOK COUNTY HOSPITAL

*Address: Registrar, 707 South Wood Street, Chicago 12, Illinois*

cinia, such as chickenpox, herpes zoster, etc.; (2) normal vaccinations which are disturbing to the patient because of the febrile reaction, pain and swelling that are to be expected with normal primary "takes"; and (3) trivial secondary inoculations on non-vital areas of the body.

A report form will accompany each shipment of VIG, and the physician is requested to complete and return it to the Research Director, Blood Program, American National Red Cross Headquarters, Washington 6, D. C.

### Ohioan Is Named To New Council Of Veterans Administration

An Ohioan was among six physicians named to the newly formed Advisory Council to the Physical Medicine and Rehabilitation Service of the Veterans Administration Department of Medicine and Surgery. Members of the council furnish advice to the VA PM&R staff in Washington, D. C., on rehabilitation therapies employed for paraplegics, the mentally ill, aging and chronically ill patients, speech therapy, and rehabilitation of the blind.

The Ohioan on the council is Dr. Meiczyslaw Peszczynski, chief of physical medicine and rehabilitation at Highland View Hospital, Cleveland, and assistant professor of physical medicine and rehabilitation at Western Reserve University School of Medicine.

### Aid for Aged Prescription Form Revised

The Aid for the Aged Form 515 has been revised and is in distribution. The space on the form which was formerly allotted to "Explanation of Special Drug Not on AFA List" has been deleted as such is no longer required. The form is a combined prescription form and pharmacist's invoice for use in the drug program of the Division. The local Subdivision Office furnishes a reasonable supply of the Form AFA 515 to physicians, dentists, and participating pharmacists on their request in relationship to usage.

All prescriptions are to be original prescriptions. A phoned-in prescription may be filled by the pharmacist. Drugs dispensed as refills of prescriptions will not be paid for by the Division.

Upon completion of the prescription, the physician can give the entire form to the patient or his agent, or send it to the pharmacist for filling. The recipient or his agent takes the prescription to the participating pharmacist of his choice, identifies himself or the patient respectively as being a recipient and the pharmacist fills the prescription.

The Division has advised that in future printings of Form 515 the words "Prescription Form" appearing diagonally across the space marked "Rx" will be eliminated as they interfere with the legibility of the prescription.


# FOR SALE

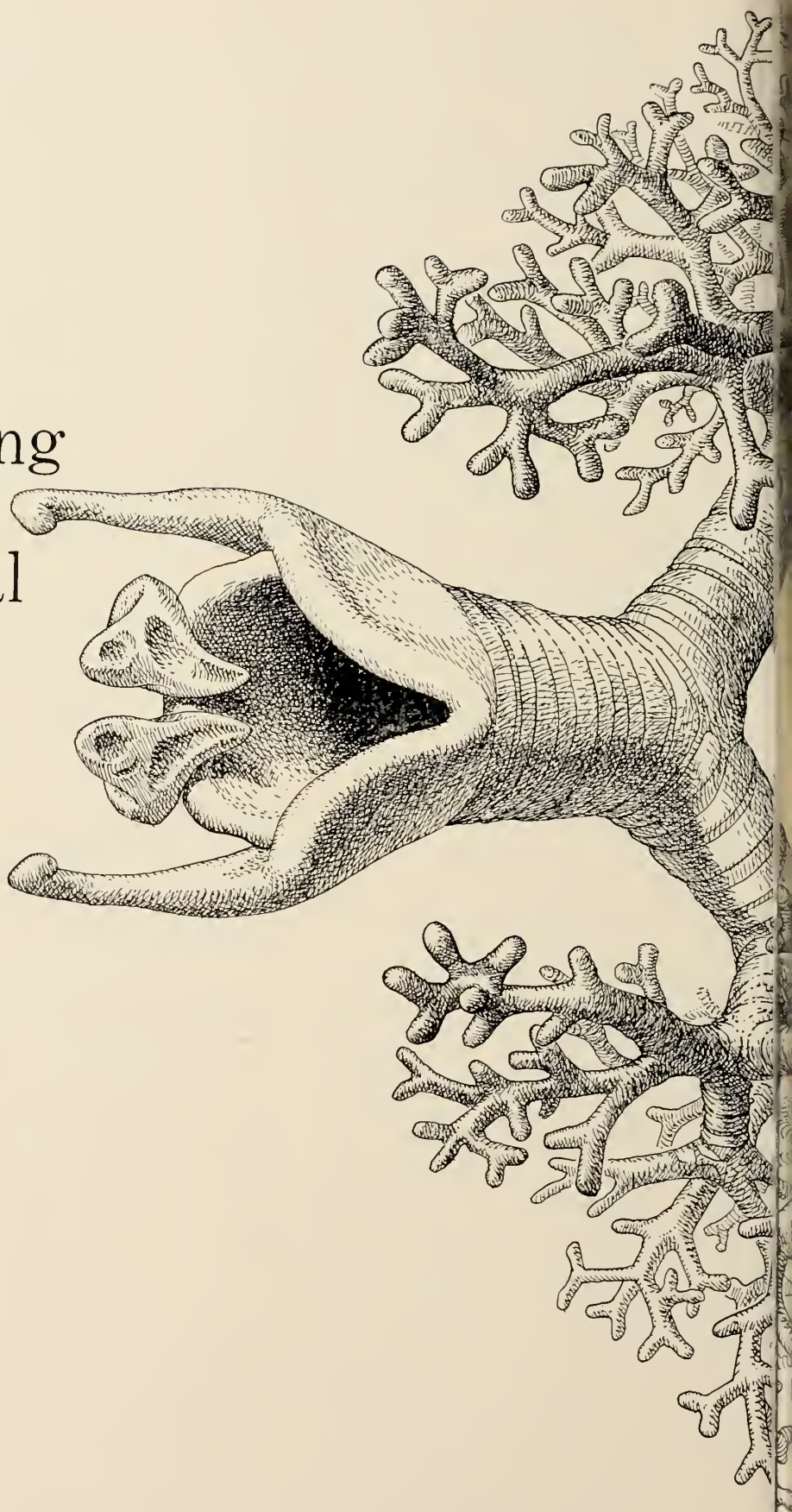
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| Victoreen R Meter—Just Been Reconditioned | $ 175.00 |
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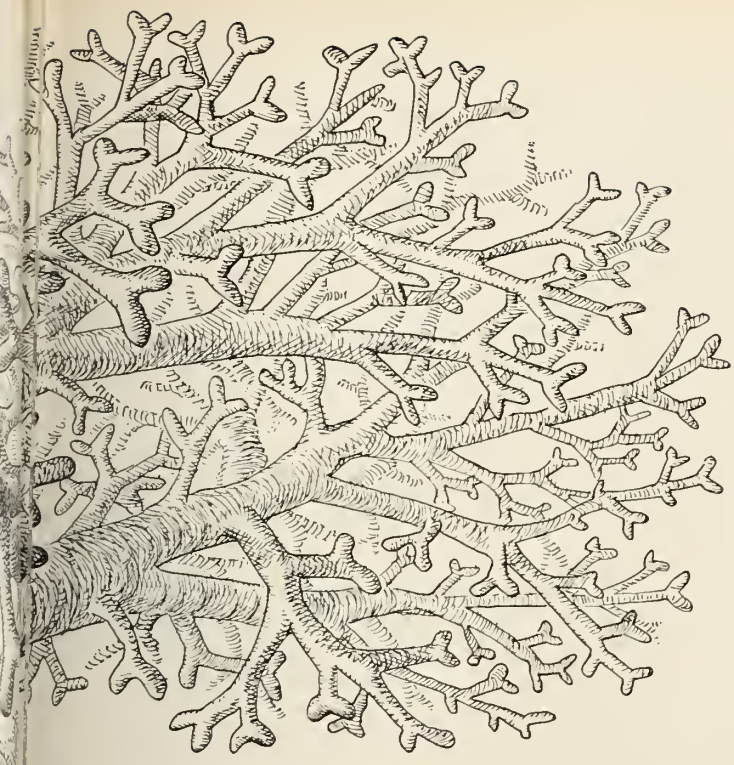
*By*

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# Workmen's Compensation . . .

## Sixth of a Series of Articles on the Ohio Program Shows Physicians How To Obtain Prompt Payment

THIS is the sixth in a series of articles being published in *The Journal* pertaining to the administration of the Ohio Workmen's Compensation Law, especially about procedures of special interest to physicians. Clip these articles for ready reference. This month's article in question-and-answer form relates to the attending physician's involvement if a Workmen's Compensation claim becomes inactive.

**What happens to medical fee bills and requests for authorization to provide treatment that are filed in a claim which has become inactive?**

The payment of fee bills and/or the granting of the request is held pending the re-opening of the claim.

**When is a claim considered inactive?**

A claim is considered inactive when there has been a lapse of a reasonable period of time between the present treatment or request and the date of the last medical treatment or the last date that conclusive compensation finding was awarded.

**How is a claim re-opened?**

A claim is re-opened by the filing of a properly completed Form C-85A, "Application For Additional Compensation Beyond the Date of Last Payment." The purpose of the form is to provide information as to the claimant's status since the last report.

**Who completes the Form C-85A?**

The form C-85A must be completed by the claimant, the attending physician, and the employer for whom the claimant was working at the time of the occupational disease.

**What information should be included in Part II, Attending Physician's Report, of the C-85A?**

1. There should be a comprehensive list of all periods during which the claimant received treatments including the date of the last examination and treatment.

2. There should be an accurate description of the nature and extent of the claimant's past and present disabilities including all objective medical signs.

3. There should be a definite statement relating the claimant's present disability to the disability recognized in the claim and the objective medical proof used in this relationship.

4. There should be a description of the present and the anticipated treatments needed by the claimant in this claim.

5. There should be an estimate of any permanent disability suffered by the claimant and a medical substantiation of any temporary periods of disability that have resulted from the injury or occupational disease recognized in this claim.

**Suggestions to the Attending Physician**

1. Place greater importance upon the date of last treatment and recommend the filing of a form C-85A if an unreasonable time period has resulted between the last treatment and the claimant's present disability.

2. The attending physician can refuse to provide further treatments until the claim has been re-opened thus assuring himself of prompt consideration of his fee bills by the timely filing of the form C-85A.

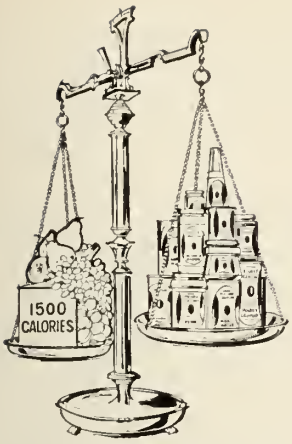
3. The form C-85A may be obtained by the claimant or his employer for use by his attending physician from any office of the Bureau of Workmen's Compensation.

**Want A Speaker on Subject of Workmen's Compensation?**

The Bureau of Workmen's Compensation and the Industrial Commission of Ohio will be happy to provide a speaker on Workmen's Compensation, with special emphasis on fee bills, claims procedure and related subjects. Requests should be directed to: Mr. George H. Thompson, Chief Deputy Administrator, Claims Section, Bureau of Workmen's Compensation, Columbus 15, Ohio.

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Charles C. Edwards, M. D., has been named assistant director of the AMA's Council on Medical Education and Hospitals. Dr. Edwards, who will join the staff in September, will be primarily concerned with graduate medical education. He formerly served as a consultant on medical education and manpower in the Dept. of Health, Education and Welfare.




# A new answer to one of America's leading health problems

## 60 DELICIOUS FOODS THAT MAKE WEIGHT CONTROL EASIER!

**Here is a practical** and down-to-earth method to help overcome obesity, the nation's No. 1 diet problem—and prime stealer of doctor's consultation time. Now a new group of 60 delicious Mott's Figure Control Food products uses the best of nutrition knowledge to create quality dishes, lower in calories by an average of 50%. Indicated calorie savings can be made pleasantly and accurately while eating normal-size portions by using these calorie-controlled foods in place of higher calorie dishes. Protein, vitamin and mineral food values are retained.

**Low carbohydrate, low fat:** Fats are largely extracted from meats and poultry in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids, all are delectably "natural" and tempting in flavor. Fruits, juices, desserts and sauces are prepared where indicated with non-caloric sweeteners—natural fruit values are intact, extra sugars reduced. The carbohydrate, protein and fat content appears on all labels along with the calorie count. Useful for diabetic diets, too.

**Easy medical tool for doctors:** Less need for drugs, no possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods include: Soups, Meats & Poultry, Popular Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts and Sweeteners.

### New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

| | Quantity | Figure Control Calories | "Regular" Food Calories |
|---|---|---|---|
| Apple-Grape Drink | ½ cup | 20 | 52 |
| Five-Fruit Juice Breakfast Drink | ½ cup | 20 | 52 |
| Braised Beef and Vegetables | 6½ oz. | 184 | 380 |
| Meat Balls in Brown Gravy | 3½ oz. | 84 | 280 |
| Chopped Chicken Livers | 1 oz. | 31 | 100 |
| Chicken a la King | 3 oz. | 72 | 230 |
| French Style Dressing | 1 tbsp. | 10½ | 60 |
| Brown Gravy | 1 tbsp. | 7 | 21 |

| | Quantity | Figure Control Calories | "Regular" Food Calories |
|---|---|---|---|
| Applesauce | ½ cup | 48 | 90 |
| Fruit Cocktail | ½ cup | 44 | 90 |
| Cherry Pie Filling | 1 oz. | 20 | 60 |
| Chocolate Topping | 1 tbsp. | 8 | 63 |
| Preserves (Peach, Strawberry) | 1 tbsp. | 9 | 55 |
| "Maplette" Syrup | 1 tbsp. | 9 | 55 |
| Liquid or Powder Sweetener | (to equal 1 tbsp. of sugar) | 0 | 16 |




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# Buckeye News Notes . . .

Ada—Dr. Robert E. Elliott summarized the American Medical Association's opposition to H. R. 4222 and urged Sabin polio immunization for all in a recent talk before Ada Rotarians.—*Ada Herald.*

Bowling Green—Dr. Roger A. Peatee spoke before a recent meeting of the Bowling Green Kiwanis Club concerning the rejected medicare plan, sponsored by President Kennedy.

Chillicothe—Dr. H. M. Crumley spoke on "Medical Care for the Aged Through Social Security" at a recent meeting of the Ross County Republican Women's Club.—*Chillicothe Gazette.*

Cincinnati—Dr. Mary T. McGloin, a member of the Good Samaritan Hospital staff, spoke on "First Aid in Cardiac Failure" before a recent meeting of the Cincinnati Club's Reciprocity Table.

Columbus—Dr. Frederick Hopkins Shillito, former medical director, Atlantic Division, Pan American World Airways, has joined the faculty of the Ohio State University College of Medicine as a professor of preventive medicine (aviation medicine) and clinical professor of internal medicine. Dr. Shillito's principal association will be with the department of preventive medicine, in which he will work chiefly in the educational and research programs in aviation medicine.

Columbus—Dr. James L. Henry of Grove City, past-president of the Columbus Academy of Medicine, was among panelists at the Midwest Pharmaceutical Advertising Club seminar held in Chicago recently. Dr. Henry's topic was "Your Problems Interest Us — They Are Our Problems Also."—*Columbus Dispatch.*

Dayton—Dr. Peter Granson spoke on the defeat of the King-Anderson Bill before a recent meeting of the Dayton Sertoma Club.

East Liverpool—Dr. Alexander S. Fisher was the guest speaker at a meeting of the newly organized Columbiana County Pharmaceutical Association. He discussed the advantages of a professional organization and its benefit to the community.

Fostoria—The Seneca County Young Republicans Club heard Dr. O. G. Burkart speak on the Medicare bill at the club's July meeting.

Marietta—The administration backed King-Anderson bill to provide medical care for the aged was attacked by Dr. Richard R. Hille, Marietta, at a recent luncheon meeting of the Marietta Lions Club.

Middletown—"Medicare" was the subject of a talk by Dr. Robert A. Tennant before the Middletown Young Republican Club at the organization's July meeting.

Portsmouth—Dr. Chester H. Allen was the speaker recently at the Torch Club's meeting. Dr. Allen's topic was "Medical Care for the Aged."—*Portsmouth Times.*

Ravenna—Drs. E. A. Webb and R. R. Roy recently discussed the proposed medical care program for the elderly before the weekly meeting of the Ravenna Rotary Club. Their talk was titled "Health — and Politics."—*Ravenna Courier.*

Troy—Dr. Theodore L. Light, Dayton, spoke recently to members of the Troy Lions Club on the subject of health care for the aged. He discussed various types of plans, how they could be operated, and their cost.


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# Family Health Expenditures . . .

## Larger Income Families as a Rule Have Higher Health Costs; Other Interesting Data Revealed

FAMILIES with heavy expenditures for health are generally larger in size and have higher incomes than average, and a higher-than-average proportion of their health spending is covered by voluntary health insurance.

These findings were reported by Health Information Foundation in its monthly statistical bulletin, *Progress in Health Services*. They come from a recent survey of 2,941 families, representing a random cross-section of the United States, conducted jointly by the Foundation and the University of Chicago's National Opinion Research Center.

### Upper Spending Group

Almost one-third of the surveyed families—31.6 per cent—reported annual spending of $300 or more for all personal health services, such as physicians' and dentists' charges, hospital care, drugs, private-duty nursing, eyeglasses, and appliances. In this high-spending group, 47 per cent spent between $300 and $499, 38 per cent between $500 and $999, and the remaining 15 per cent $1,000 or over.

The entire group of high-spending families, the Foundation said, accounted for about three-fourths of all private expenditures on health—$12 billion of the $16.2 billion spent by the American public for this purpose in the survey year of 1957-58.

Among other findings about high-expenditure families reported by the Foundation:

The incomes of high-spending families were usually above average. For example, only 18 per cent of the families spending $1,000 or over had annual earnings of less than $3,500, against a comparable 34 per cent of all families.

High-spending families were larger than average in size. Whereas 44 per cent of all families consisted of two persons or less, only 31 per cent of the $1,000-and-over group were in this category.

### Physician-Hospital Care

High spenders required considerably more physicians' services (particularly surgical) and hospital care than average. Among all families the average annual expenditure on physicians and hospital care came to $98 and $68, respectively, while the comparable figures for all high spenders ($300 or more on all health items) were $231 and $195. Surgical bills alone averaged $19 for all families and $57 for the $300-and-over group.

Voluntary health insurance coverage was especially prevalent among families spending $1,000 or more; 88 per cent of them had such insurance, against 69 per cent of all families. The insured $1,000-and-over families had an unusually high proportion of their total expenses covered by their insurance—35 per cent, against only 24 per cent for all insured families.

Commenting on this finding, George Bugbee, Foundation president, pointed out that "Voluntary health insurance was originally devised to cover primarily costs of hospital care and surgery." As a general premise, he added, "the emphasis on hospital-surgical coverage was sound," since the relative importance of these two items in the family health bill becomes greater as total spending increases.


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**Early, efficient reduction of blood pressure.** Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"[1]) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents[2-8] provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron® (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide[9]; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

**Added advantages for long-term or difficult patients.** Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide/rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

**Each Salutensin tablet contains:** 50 mg. Saluron® (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

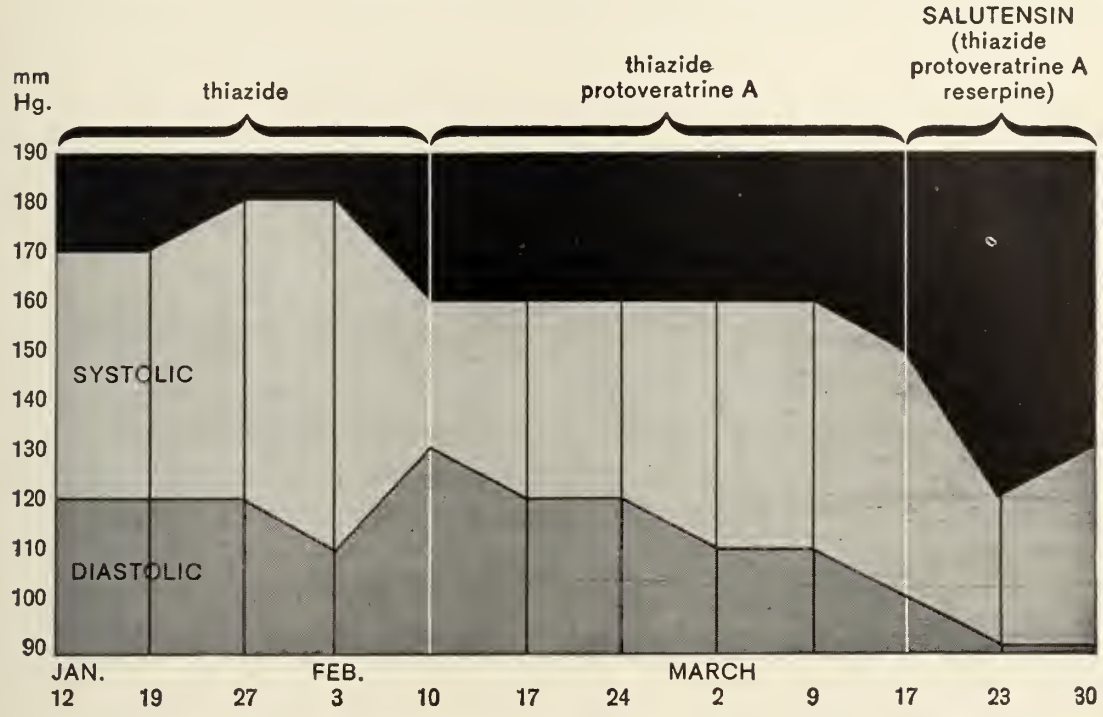
**Supplied:** Bottles of 60 scored tablets.

**References:** 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

## all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific, physiologic vasodilation of protoveratrine A

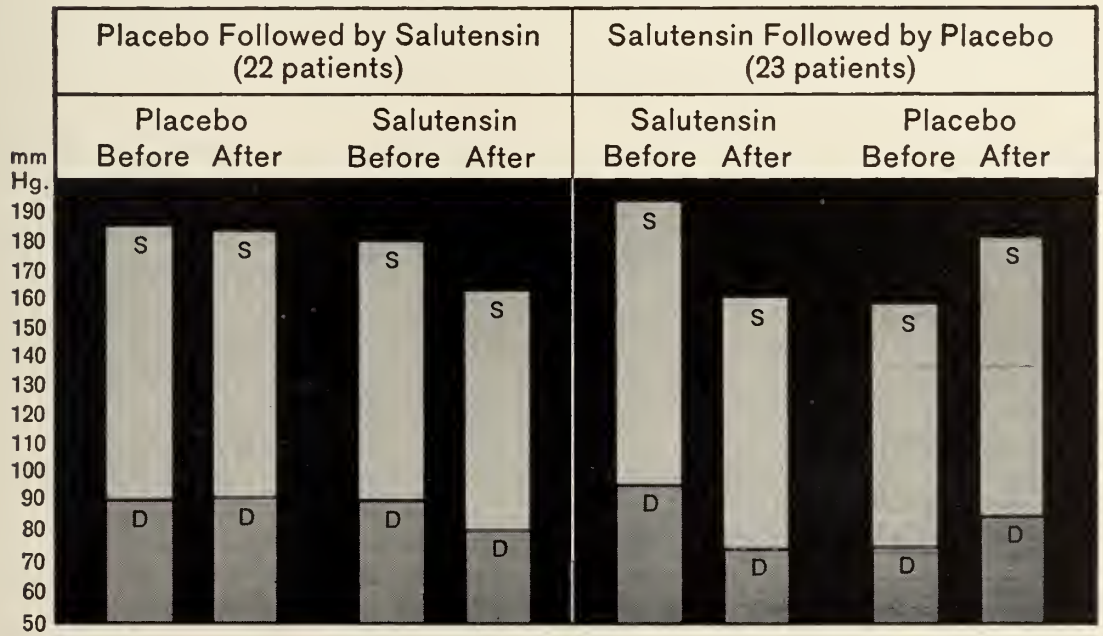
**11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE**

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)




**3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY**

Mean Blood Pressures–Systolic (S) and Diastolic (D)




In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

BRISTOL LABORATORIES/Div. of Bristol-Myers Co., Syracuse, N.Y.

# Do You Know? . . .

Dr. Jack Cole, associate professor of surgery at the Western Reserve University School of Medicine and associate surgeon at University Hospitals, has been awarded an Eleanor Roosevelt International Cancer Research Fellowship for 1962. Dr. Cole left in early June to spend one year studying forms of intestinal cancer in the research department of St. Mark's Hospital in London, England.

* * *

Dr. Leonard B. Goldberg, Cleveland, has been appointed medical director by the General Life Insurance Company.

* * *

Pioneer work in arterial disease leading to a new method of diagnosing obstructions in arteries has brought Dr. F. Mason Sones, Jr., of the Cleveland Clinic a $258,000 research grant. Dr. Sones, as head of the clinic's cardiac laboratory received the grant from the John A. Hartford Foundation, Inc., to further his search for new diagnostic techniques and equipment for arterial surgery.

* * *

Dr. Robert E. Walden, formerly with the veterans hospital in Pittsburgh, has been named superintendent of the Lakin State Hospital, Point Pleasant.

* * *

Kenneth C. Evans has resigned as assistant executive secretary, Montgomery County Medical Society, to become assistant executive director of the Columbus Bureau of Medical Economics.

* * *

Dr. Mary A. Agna was recently placed on permanent status as Clark County health commissioner. Dr. Agna was serving in that capacity on a 90-day initial probationary period.

St. Luke's Hospital, Cleveland, has been awarded $113,400 from the National Heart Institute to support a development training program to strengthen the hospital's research and education program in the heart and blood vessels field. Acting head of the project will be Dr. Albert Mowlen, director of the department of surgical research.

* * *

Dr. Carl W. Walter, a former Clevelander, has been appointed clinical professor on the Harvard Medical School faculty.

* * *

Dr. William J. Flynn, Youngstown, president of the Ohio Division, American Cancer Society, attended the Eighth International Cancer Congress in Russia in late July. Also attending this meeting, was Dr. Paul Mesaros of Youngstown.

* * *

Dr. Henri Kerns has been named to fill a vacancy on the Kenton city council. Dr. Kerns has served as chairman of the City Charter Commission.

* * *

Harry C. Eader has been appointed Secretary and Consultant to the Board of Trustees of the Ohio Hospital Association and Donald R. Newkirk, presently Associate Director, has been appointed Executive Director, succeeding Eader.

* * *

Occupancy of a new $50,000 Mental Health Center at Defiance that will serve Defiance, Fulton, Henry and Williams Counties began on July 16.

* * *

Dr. John W. Zimmerly, formerly of Sterling, flew to Puerto Rico on July 9 to begin two years of service at Mennonite General Hospital.


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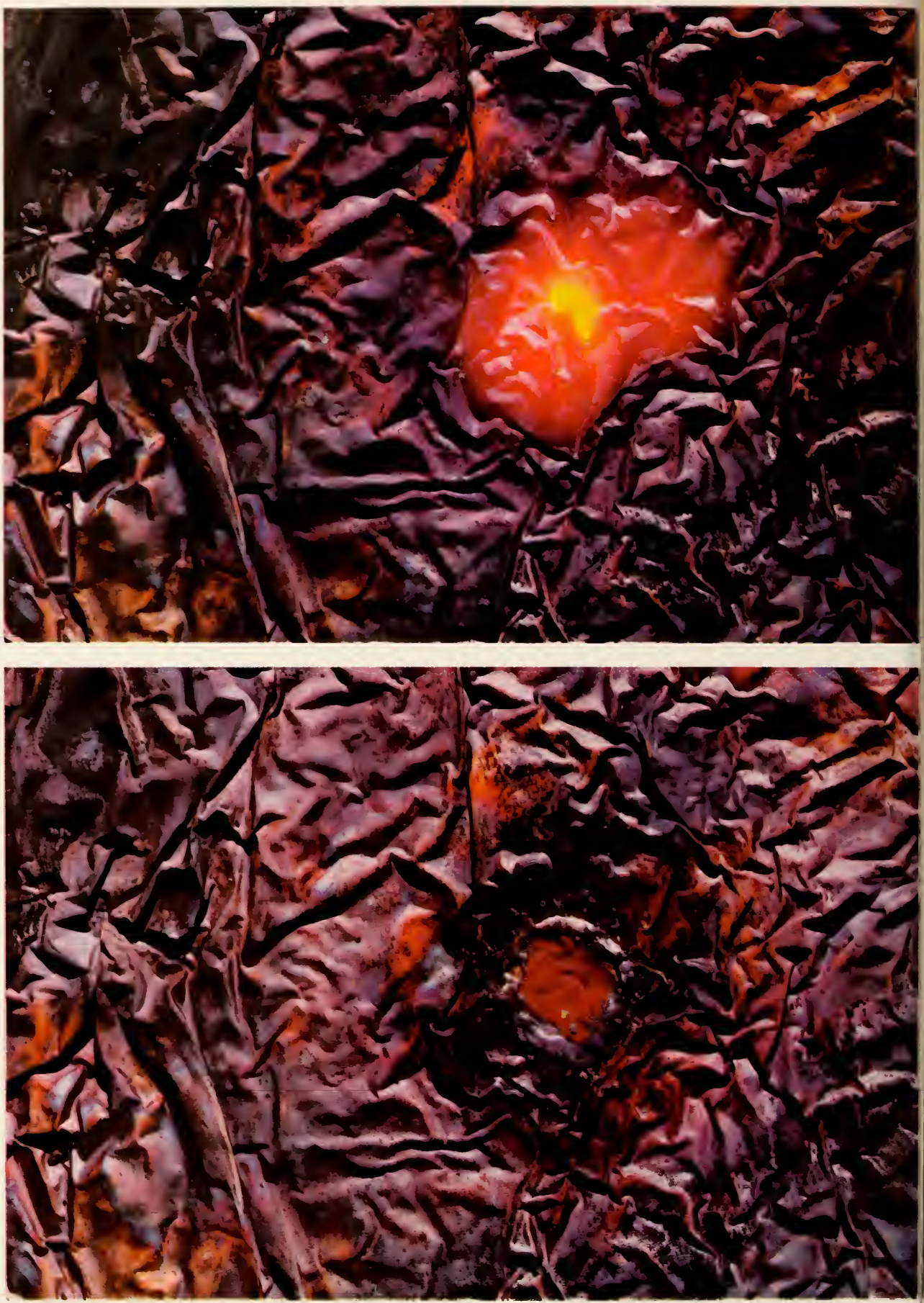
*References:* 1. Clinical report on file, Medical Department, A. H. Robins Co., Inc. 2. Schiller, I. W., & Lowell, F. C.: New England J. Med. *261*:478, 1959.

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The illustration: To dramatize the pain and trauma and healing of the peptic ulcer, our photographer burned a "lesion" into crumpled metal with a blowtorch and photographed it, then repaired the damage and rephotographed the result — the "healed" ulcer.

# ulcer under repair

**"What results can I expect in my ulcer patients?"** Shown below is a tabulation of 795 ulcer patients, reported by 69 investigating physicians, in which glycopyrrolate was the anticholinergic employed. They represent a cross section of ulcer patients of all ages, both ambulatory and hospitalized, under various regimens, from all sections of the country.

Note the pattern of results. Robinul showed an "excellent" or "good" response in over 83% of patients, and Robinul-PH provided similar results in 81%.

As for side effects, these often troublesome extensions of anticholinergic action such as dry mouth, blurred vision, etc., were evaluated as "moderate-to-severe" in only 6.7% of a total of 1705 patients in preliminary investigative studies, 795 of whom are the ulcer cases tabulated here.

We invite you to try Robinul in your own practice. We believe you will find it one of the most effective agents you have ever used for the management of the ulcer patient.

**Robinul®** (formerly Robanul)
Each tablet contains glycopyrrolate, 1.0 mg.

**Robinul®-PH** (formerly Robanul-PH)
Each tablet contains glycopyrrolate, 1.0 mg.; and phenobarbital (¼ gr.), 16.2 mg.

# Robinul® at work

Brand of glycopyrrolate, Robins

**results with Robinul and Robinul-PH in 795 ulcer patients, from 69 clinical investigators***

| DIAGNOSIS | ROBINUL | | | | | ROBINUL-PH | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *No. Patients | Excellent | Good | Fair | Poor | *No. Patients | Excellent | Good | Fair | Poor |
| Marginal Ulcer | 11 | 3 | 3 | 3 | 2 | 1 | 0 | 1 | 0 | 0 |
| Pyloric Channel Ulcer | 6 | 3 | 1 | 0 | 2 | 2 | 1 | 1 | 0 | 0 |
| Pyloric Ulcer | 4 | 2 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 |
| Gastric Ulcer, bleeding | 3 | 1 | 2 | 0 | 0 | | | | | |
| Gastric Ulcer | 48 | 31 | 11 | 1 | 5 | 12 | 5 | 7 | 0 | 0 |
| Gastric Ulcer, penetrated | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 |
| Gastric Ulcers, multiple | 1 | 1 | 0 | 0 | 0 | | | | | |
| Duodenal Ulcer | 494 | 220 | 195 | 48 | 31 | 99 | 41 | 38 | 13 | 7 |
| Duodenal Ulcer, bleeding | 38 | 19 | 15 | 3 | 1 | 2 | 1 | 0 | 1 | 0 |
| Duodenal Ulcer, obstruction | 13 | 4 | 3 | 1 | 5 | | | | | |
| Duodenal Ulcer, perforated | 5 | 2 | 1 | 0 | 2 | 6 | 0 | 3 | 1 | 2 |
| Gastric and Duodenal Ulcer | 4 | 2 | 2 | 0 | 0 | | | | | |
| Peptic Ulcer, unspecified | 25 | 19 | 4 | 0 | 2 | 18 | 8 | 7 | 2 | 1 |
| TOTALS | 653 | 307 | 239 | 57 | 50 | 142 | 58 | 57 | 17 | 10 |
| | | 83.6% | | | | | 81.0% | | | |

*Clinical reports on file, A. H. Robins Company, Inc.

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Richmond 20, Virginia

# Clinical Practice in the Hospital...

## Evaluating Clinical Work Is Grave Responsibility Of Physicians. Joint Commission Bulletin States

"IT is the responsibility of the entire active medical staff to analyze, review, and evaluate the clinical practice in the hospital and to insist on high standards of performance from each of its members," writes Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals in Bulletin No. 24 of the commission.

The complete text of that communication, because of its importance, is being published herewith by *The Journal* as follows:

"Only physicians are capable of judging what is or what is not good medical practice. Patients and hospital personnel may learn to recognize good practice, but the physician can accurately evaluate its quality.

### Staff Responsibility

"The opinions of individual physicians vary and rightly so. For that reason, the Commission places heavy emphasis on group participation in evaluating clinical practice. It is the responsibility of the entire active medical staff to analyze, review, and evaluate the clinical practice in the hospital and to insist on high standards of performance from each of its members.

"This responsibility is not easily discharged. It requires hours of work which the busy physician can ill afford to spend and which is usually done at the expense of his personal pleasures. It requires an objectivity which is perhaps even more difficult to achieve. To judge the work of a colleague on a fair, unbiased, impartial level calls for the intelligence and wisdom of a Solomon. That this is so well done in thousands of hospitals can be attributed to the integrity, effort, and persistence of each member of the medical staff.

### Essentials Listed

"In order to evaluate clinical practice the following are essential:

"**Reliable Medical Records:** There must be evidence on the medical record that the diagnosis was made on the basis of information given by the patient in the history, a careful physical examination, and a scientific interpretation of the findings. There must be sufficient data recorded to justify the physician's treatment of the patient and the results. For the sake of both the group whose responsibility it is to review the record and the physician whose performance is being evaluated, a good medical record is indispensable.

"**Reliable Reports of Diagnostic Tests:** The physician must rely on the accuracy of reports on laboratory and diagnostic tests. The medical staff cannot supervise all these areas, but it has a responsibility to make certain that there is supervision. This is done by recommending the appointment of qualified individuals to head these departments and to designate those on the staff qualified to interpret electrocardiograms, x-rays, and other diagnostic tests. If laboratory work is done outside the hospital, it must be made certain that these laboratories are government approved, licensed, and under the direct supervision of a pathologist.

"**An Organized Medical Staff:** To insure a continual orderly process of evaluating clinical practice, the medical staff must be formally organized. This provides a framework in which the duties and functions of the staff can be carried out. The medical staff may decide to delegate the responsibility of clinical review to committees, to clinical departments, or to the staff as a whole. Only the individual medical staff can determine the method which will be most effective in the local situation.

"**Competent Medical Staff:** Though listed fourth, the most important factor in evaluating clinical practice is a competent medical staff. The quality of medical care in the hospital is in direct ratio to the knowledge, experience, and ability of the members of the medical staff. The judgment necessary to evaluate clinical practice depends entirely on the ability of those who are doing the evaluating.

"This makes the appointments to the staff and the delineation of privileges so important. To do this fairly and objectively, the medical staff should set up a system to evaluate each applicant and determine his hospital privileges on the basis of professional competence. Individual character, training, experience, and ability should be the criteria for selection. Under no circumstances should the accordance of staff membership or professional privileges in the hospital be dependent solely upon certification, fellowship or membership in a specialty body or society. Neither should appointments be denied on the basis of hospital bed

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capacity or selfish competitive motives on the part of the staff.

### Helps Staff, Too

"Although the primary purpose of clinical review is to achieve and maintain high standards of patient care, the process also serves as a means of evaluating the performance of individual staff members. The judgment, ability, and competence of a staff member can be assessed by his methods of diagnosis, his skill in treatment, and his ability to recognize situations which call for consultation. These facts should influence the decision to extend or limit his hospital privileges. Each member of the staff should be given the opportunity to realize his full capabilities, and at the same time safeguards must be established to protect patients. By good clinical review both patient and staff member profit.

### Matter of Great Emphasis

"The Commission in accrediting a hospital places great emphasis on the extent and care with which the medical staff reviews and evaluates clinical practice. Since good medical records, reliable diagnostic services, and a competent, well organized staff are essential for good clinical review, these factors are closely surveyed. To be accredited, there must be evidence that the hospital medical staff is living up to its important responsibilities."

---

# New Members . . .

The following are the names of the new members of The Ohio State Medical Association since July 1, 1962. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Franklin**

William D. Bolander, Worthington
Ludwig Gere, Columbus
Thelma L. Herwig, Columbus
Theodor F. Herwig, Columbus

**Gallia**

Alfredo Corona, Gallipolis

**Jefferson**

Alfonso Z. Ricohermoso, Richmond

**Lake**

Ernesto R. Garcia, Willoughby

**Muskingum**

Eugene Capocasale, Zanesville

**Portage**

Florencio A. Marquinez, Kent

**Summit**

Otto N. Bernath, Mogadore
Dennis Ross Irons, Akron
Charles E. Pratt, Akron
Joseph A. Sonta, Akron

**Trumbull**

Oscar F. Gutierrez, Niles

**Wayne**

Lyle W. Moyer, Dalton

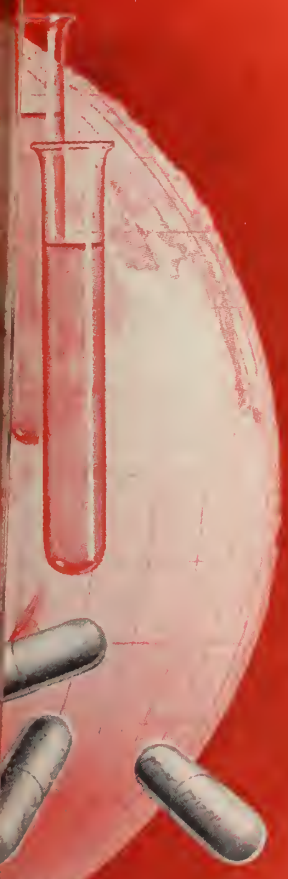
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**Noise and Hearing.** Report contains information obtained from hearing tests given 2,000 employees of the Federal Prison Industries and correlates these tests with factory noise measurements. It is expected to be valuable in defining working conditions that will not endanger hearing ability. This is Public Health Service Publication No. 850. Write Public Health Service, U. S. Department of Health, Education & Welfare, Washington 25, D. C.



# from boutonneuse fever in Africa

Whether treating boutonneuse fever, bronchopneumonia, or a host of other infections, physicians throughout the world continue to rely on the effectiveness, relative safety, and exceptional toleration of Terramycin in broad-spectrum antibiotic therapy. This continuing confidence is based upon thousands of published clinical reports and successful experience in millions of patients. *The next infection you see will more than likely be "Terra-responsive."*



**IN BRIEF** The dependability of Terramycin in daily practice is based upon its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using.

*More detailed professional information available on request.*

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**Boutonneuse fever** is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

# to bronchopneumonia in Ohio

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intramuscular solution • intravenous

also available with nystatin as TERRASTATIN® (capsules and oral suspension)

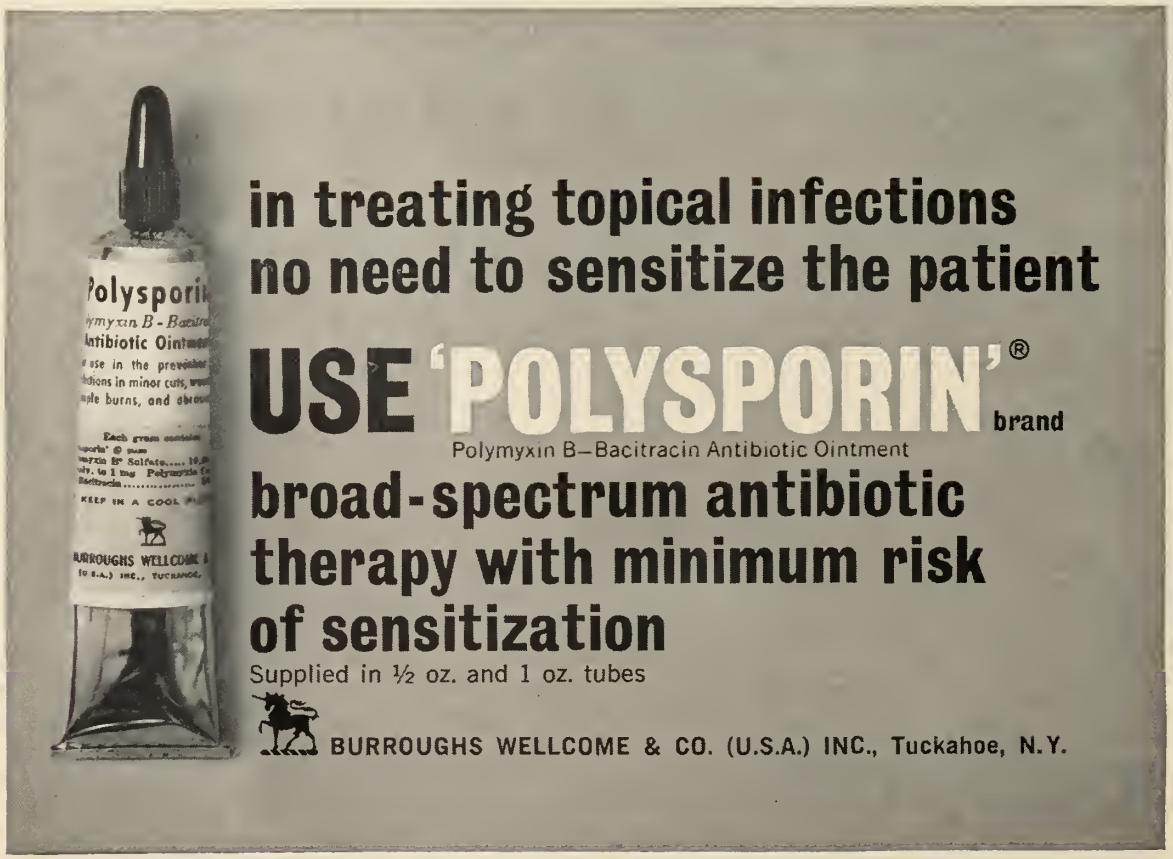
# Ad Astra

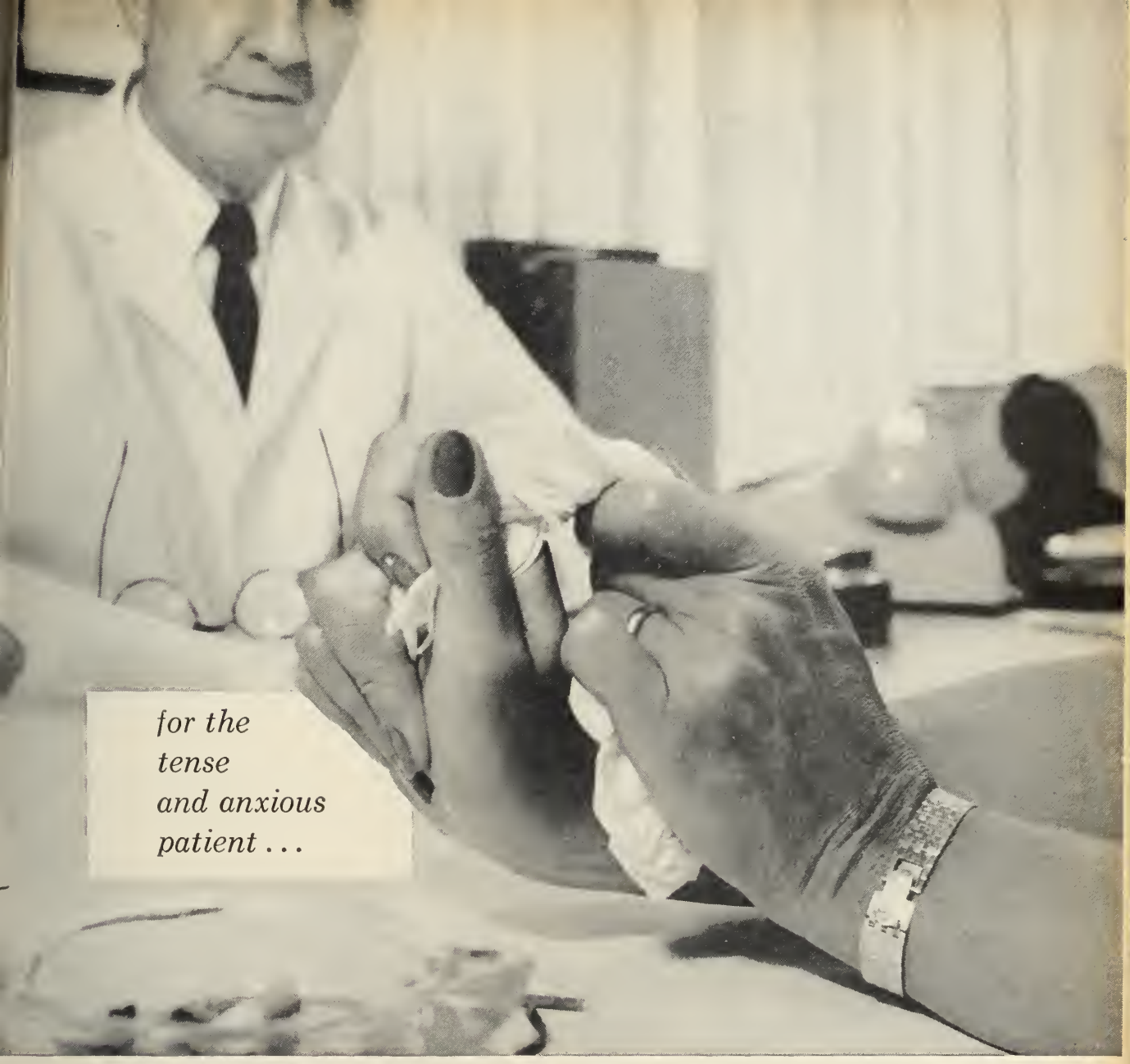
John Donald **Brett**, M. D., Cleveland; Western Reserve University School of Medicine, 1936; aged 52; died July 20; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Brett was a native of Shaker Heights and served virtually all of his professional career in the Cleveland area. He was a veteran of World War II, having served in the Army Air Corps as a medical officer. Affiliations included membership in several Masonic bodies. Survivors are his widow, two daughters and a sister.

Ord William **Burkholder**, M. D., Toledo; Ohio State University College of Medicine, 1924; aged 68; died July 24; member of the Ohio State Medical Association, the American Medical Association, International College of Surgeons and Fellow of the American College of Surgeons. A native of the northwest part of the State, Dr. Burkholder began his practice in Toledo after completing an internship in Pittsburgh. A veteran of World War I, he was a member of the Lutheran Church and the Masonic Lodge. Surviving are his widow, a daughter, a sister and two brothers.

Thomas Harold **Copeland**, M. D., Bedford; Jefferson Medical College of Philadelphia, 1919; aged 69; died July 26; member of the Ohio State Medical Association and the American Medical Association. A native of Athens, Dr. Copeland was the son of the late Dr. and Mrs. Thomas A. Copeland. He began practice in Bedford upon completion of his medical training. Affiliations included memberships in the Masonic order and the American Legion. Surviving are a daughter and two sisters.

William Morse **Hicks**, M. D., St. Petersburg, Florida (formerly of Cincinnati); Jefferson Medical College of Philadelphia, 1914; aged 75; died July 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Hicks practiced






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for nearly 30 years in Cincinnati before retiring in 1954. He is survived by a son, Dr. W. Morse Hicks, Jr., of Victoria, Texas, and two daughters.

**Lyle Steen Hill,** M. D., Sandusky; Wayne State University College of Medicine, 1914; aged 81; died July 25; former member of the Ohio State Medical Association. Dr. Hill took his internship in Cleveland and practiced seven years there before moving to Sandusky. For several years before retiring he was employed in the testing laboratory of the Farrell Cheek Steel Company. Survivors include a son and a daughter.

**Emery George Kyle,** M. D., Newton Falls; Medical College of Virginia, 1932; aged 62; died August 1; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice; former president of the Trumbull County Medical Society. A native of Youngstown, Dr. Kyle took his internship there and began his practice in Newton Falls in 1933. In addition to his professional associations, he was active in numerous community affairs; was a member of the Kiwanis Club, and several Masonic bodies. Surviving are his widow, a son and his mother.

**John Ambrose Lampe,** M. D., Cincinnati; St. Louis University School of Medicine, 1935; aged 56; died August 1; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Lampe served all of his professional career in the Cincinnati area practicing mainly in the Price Hill area district. A member of the Catholic Church, he is survived by his widow, a son, a sister and a brother.

**Dwight C. Pettay,** M. D., Cadiz; University of Cincinnati College of Medicine, 1939; aged 50; died July 8; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Harrison County, Dr. Pettay returned to the Cadiz area to practice upon completion of his medical training. He was active in a number of local projects, such as the local athletic program. Among affiliations he was a member of the Methodist Church and several Masonic bodies. Survivors include his widow, two sons, two daughters, two brothers and his stepmother.

**Margaret Nemet Prehal,** M. D., Cleveland; medical degree from the University of Budapest; aged 36; died July 14. Dr. Prehal was the wife of Dr. Julius S. Prehal. She and her husband practiced in Hungary before coming to this country. She became associated with the Lutheran Hospital in 1957 and later became associated with the Fairview Park Hospital. Besides her husband, she is survived by a brother in France.

**Everett William Shank,** M. D., Dayton; Columbia University College of Physicians and Surgeons, 1913; aged 83; died July 5; member of the Ohio State Medical Association, the American Medical Association and the American College of Gastroenterology; diplomate of the American Board of Internal Medicine. Dr. Shank practiced medicine for more than 40 years in the Dayton area where he specialized in the field of gastroenterology. He was a veteran of World War I. Survivors include his widow and a son.

**Charles Frederic Smoot,** M. D., Bexley; Ohio State University College of Medicine, 1926; aged 60; died July 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Smoot practiced for many years in the Columbus area, and was anesthesiologist at Grant Hospital for some time. A veteran of World War I, he is survived by his widow, a son and two brothers.

**Martin Bennett Taliak,** M. D., Cleveland; University of Michigan Medical School, 1930; aged 57; died July 31; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. A resident of the southwest area of Greater Cleveland since boyhood, Dr. Taliak returned there to practice upon completion of medical training. He was clinical professor of surgery at Western Reserve and a director of the Academy of Medicine of Cleveland. A veteran of World War II, he is survived by his widow, two sons, three daughters, a sister and two brothers.

**Winston Francis Walker,** M. D., Cleveland; Western Reserve University School of Medicine, 1926; aged 62; died July 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Walker practiced for some 35 years in the Rocky River area of Greater Cleveland. Among affiliations he was a member of the Masonic Lodge. Surviving are his widow; a son, Dr. Richard Walker of Novato, Calif.; a daughter, and a sister.

## American Medical Writers' Association To Meet

"The Information Explosion — Its Challenge and Problems" will be the theme of the 19th annual meeting of the American Medical Writers' Association at the Sheraton Park Hotel in Washington, D. C., October 12-13.

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LAKE—Maxwell E. Burnham, President, 358 Bank St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor. 2nd Wednesday, monthly, of January, March, May, September and November.

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## County Societies' Officers and Meeting Dates (Continued)

MORGAN—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta. Called Meetings.

MUSKINGUM—Rankin A. Nebinger, President, Third St., Roseville; Benjamin W. Gilliotte, Secretary, 821 Market St., Zanesville. 1st Tuesday, monthly.

NOBLE—Frederick M. Cox, President, First National Bank Bldg., Caldwell; Edward G. Ditch, Secretary, 415 Main St., Caldwell. 1st Tuesday, monthly.

PERRY—Sydney N. Lord, President, E. Main St., Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—Clarence E. Ash, President, Marietta Memorial Hospital, Marietta; Tuathal P. O'Maille, Secretary, Marietta Memorial Hospital, Marietta. 2nd Wednesday, monthly.

### NINTH DISTRICT

GALLIA—Norman W. Pinschmidt, President, The Gallipolis Clinic, Gallipolis; Thomas P. Price, Jr., Secretary, The Holzer Clinic, Gallipolis. Last Thursday, monthly.

HOCKING—John W. Doering, President, 42 N. Spring St., Logan; Howard M. Boocks, Secretary, Court House, Logan. Called meetings.

JACKSON—John M. Cook, President, Oak Hill Hospital, Oak Hill; Brinton J. Allison, Secretary, Court House, Jackson. Called meetings.

LAWRENCE—Ralph F. Massie, President, 408 Washington St., Ironton; George Newton Spears, Secretary, 2213 South Ninth St., Ironton. Called meetings.

MEIGS—Joseph J. Davis, President, 306 N. 2nd St., Middleport; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy. Called meetings.

PIKE—Robert M. Andre, President, Lake White, Rt. 2, Waverly; Kenneth Wilkinson, Secretary, 330 E. Main St., Waverly. 1st Tuesday, monthly.

SCIOTO—Spencer W. Miller, President, 1021 9th St., Portsmouth; William E. Daehler, Secretary, 1004 24th St., Portsmouth. 2nd Monday, monthly.

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FAYETTE—Robert A. Heiny, President, 414 E. Court St., Washington, C. H.; James E. Rose, Secretary, 119 E. Market St., Washington C. H.

FRANKLIN—Richard L. Fulton, President, 1211 Dublin Rd., Columbus 12; Mr. William Webb, Jr., Executive Secretary, 79 E. State St., Columbus 15. 3rd Monday, monthly, except May, June, July and August.

KNOX—Delbert C. Schmidt, President, 205 East Chestnut St., Mt. Vernon; Richard L. Smythe, Secretary, Medical Arts Bldg., Mt. Vernon. Usually 1st Wednesday, monthly.

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ROSS—Robert E. Swank, President, 172 E. Main St., Chillicothe; David McKell, Secretary, 60 Central Center, Chillicothe. 1st Thursday, monthly, except June, July and August.

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LORAIN—Roy E. Hayes, President, Elyria Medical Arts Bldg., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 214 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Nevin J. M. Klotz, President, 162 Main St., Wadsworth; Leroy G. Dalheim, Secretary, 220 East Liberty St., Medina. 3rd Thursday, monthly, except July and August.

RICHLAND—C. Karl Kuehne, President, 480 Glessner Ave., Mansfield; Carroll E. Damron, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—G. G. Stitzinger, President, 1800 Beall Ave., Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday, monthly.

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Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

**Physicians seeking locations in Ohio** are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

ATTRACTIVE OFFICE FOR GENERAL PRACTICE with x-ray and dark room. Good hospital near by. Close to Cleveland - Akron - Youngstown. Will rent or sell outright or land lease contract. This community is planning to build a shopping center almost across the street from this office. Box 259, c/o Ohio State Medical Journal.

OFFICE SPACE FOR RENT due to death of physician. Established practice for 40 years. Ten miles to Dayton or Middletown hospitals. Community 3000 population. Will rent or lease office completely furnished with all equipment. Patients records also available. Box 236, c/o Ohio State Medical Journal.

COLORED OBSTETRICIAN or PEDIATRICIAN, Cin'ti, Ohio: Excellent opportunity in new medical center; No capital investment required; owner will remodel to suit; wood paneled waiting room, private office, receptionist area and examining rooms. Building also houses Medical Doctor, Medical Laboratory and Dentist Suites. June graduates invited to investigate. Wm. G. Menke, 2532 Indian Mound Ave., Cin'ti 12, Ohio.

PICKER X-RAY - FLUOROSCOPE: Tilt table; 100 MA - 100 KV with all accessories. Michael Truman, M. D., 1070 Millville Ave., Hamilton, Ohio; 895-4541 or 895-9498.

APPROX. 1500 sq. ft. available for General Practitioner or Internist; long lease available at very nominal rental; ample blacktop parking; north area of Columbus; busily traveled streets; next to modern drug store. Box 271, c/o Ohio State Medical Journal.

PRACTICE FOR SALE: Southeastern Ohio, suburban area, nice growing community of 5000 people with good hospital facilities. Box 286, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER: In Sunbury, Ohio, rapidly growing area 20 minutes from Columbus; good schools, churches, shopping and recreational areas nearby; reasonable taxes and utilities; office in new Sunbury Medical Bldg. available; hot water, heat, air conditioned. Philip Holmes, D. D. S., 1961 graduate of OSU in one side of bldg. Phone Dr. Holmes — Worth. 5-5026, or Ted L. Forman, Worth. 5-5876.

OB-GYN man, Residency trained — 3 years, Board eligible; Seeking Association or an area where services are needed. Available March 1963. Box 287, c/o Ohio State Medical Journal.

PSYCHIATRISTS or OTHER PHYSICIANS Wanted for 800 bed mental hospital located in medium-sized northern Ohio city near Lake Erie resort areas. Ohio licensure and/or ECFMG certification preferable **but not required.** Salary from $575 to $1,250 per month depending on training and experience. Furnished apartments with free utilities provided at nominal rates. Reply to: Howard R. Barton, M. D., Clinical Director, Tiffin State Hospital, Tiffin, O.

GENERAL PRACTITIONER — Immediate opening with established medical group in modern, new, fully equipped clinic in a growing suburb of Cincinnati, Ohio. Starting salary open depending on training, and experience, with additional increments thereafter and opportunity for partnership. One other general practitioner in group for scheduling time off, meetings, and vacations. Write full details regarding self, training, and military status to Box 277, c/o Ohio State Medical Journal.

CLEVELAND, OHIO: Large active 25 year General Practice left by unexpected death of Physician and Surgeon late July, 1962. Fully equipped office including OB and Surgery. Also well equipped Laboratory including new Leitz Colorimeter. Within walking distance of Western Reserve Medical Center. Also near 6 hospitals. Nurse and secretary will consider staying. Records available. Contact Mrs. John D. Brett, 2683 Rochester Rd., Shaker Hts., Ohio, or call collect HObart 9-1188, or Bemus Point, New York 3526.

HEALTH COMMISSIONER Wanted for Ottawa, County, Ohio, population 35,500. Public health experience desirable but not necessary. Salary $12,000. Cyrus R. Wood, M. D., President, Board of Health, Port Clinton, Ohio.

APPROVED ANESTHESIOLOGY RESIDENCIES—Wide clinical experience in all types of anesthesia. Excellent salary plus full maintenance. Apply: N. G. DePiero, M. D., Director, Dept. of Anesthesiology, Marymount Hospital, Cleveland 25, Ohio.

COMPLETE OFFICE EQUIPMENT, Incl. diathermy, ultrasonic ECG, for sale. Must sacrifice for very low price because of joining a group practice. Box 291, c/o Ohio State Medical Journal.

OFFICE AVAILABLE IMMEDIATELY for lease terms and cost of equipment; paneled in new brick building; across from large shopping center located between Elyria and Lorain; all utilities and air-conditioning; waiting room and consultation room furniture, and examining equipment in excellent condition. I desire to maintain only one office. Box 289, c/o Ohio State Medical Journal.

ATTRACTIVE WELL-EQUIPPED OFFICE for General Practice, for rent or lease due to death of physician; located in Cleveland area. Excellent location; patient records available. Box 290, c/o Ohio State Medical Journal.

PSYCHIATRIC RESIDENCIES available now and July 1963 — Approved 3-year progressive program in Metropolitan Detroit. University affiliations. Teaching staff of Board men, professors, analysts, outstanding visiting lecturers. Active research. Modern physical plant. Stipends: $7161 — $8101 plus Civil Service benefits. General practitioners may apply for an NIMH grant with stipends of $10,000-$12,000. Five-year career program also available. Write: Philip N. Brown, M. D., Superintendent, Northville State Hospital, Northville, Michigan.

Dr. Dell Russell, Elyria, was recently named president-elect of the Ohio State Radiological Society. Dr. Russell will assume the presidency in May, 1963, at the group's annual meeting.


## NURSING HOME FOR SALE

Fire-proof, steel-and-masonry mineral-spring sanitarium being converted into 100-bed comprehensive nursing home. Located on 2½ acre landscaped tract in Martinsville, Indiana. Ample trained help available. For drawings and details write New Highland Sanitarium Company, Martinsville, Indiana or telephone Martinsville, Dlckens 2-6814, Mr. Richard Bray.

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REFERENCES: (1) Roseman, E.: *Neurology* 11:912, 1961. (2) Bray, P. F.: *Pediatrics* 23:151, 1959. (3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.: *M. Clin. North America* 42:317, 1958. (5) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield,. Ill., Charles C Thomas, 1954, p. 190. (6) *Ibid.*: *Postgrad. Med.* 20:584, 1956. (7) Merritt, H. H.: *Brit. M. J.* 1:666, 1958. (8) Carter, C. H.: *Arch. Neurol. & Psychiat.* 79:136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (10) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

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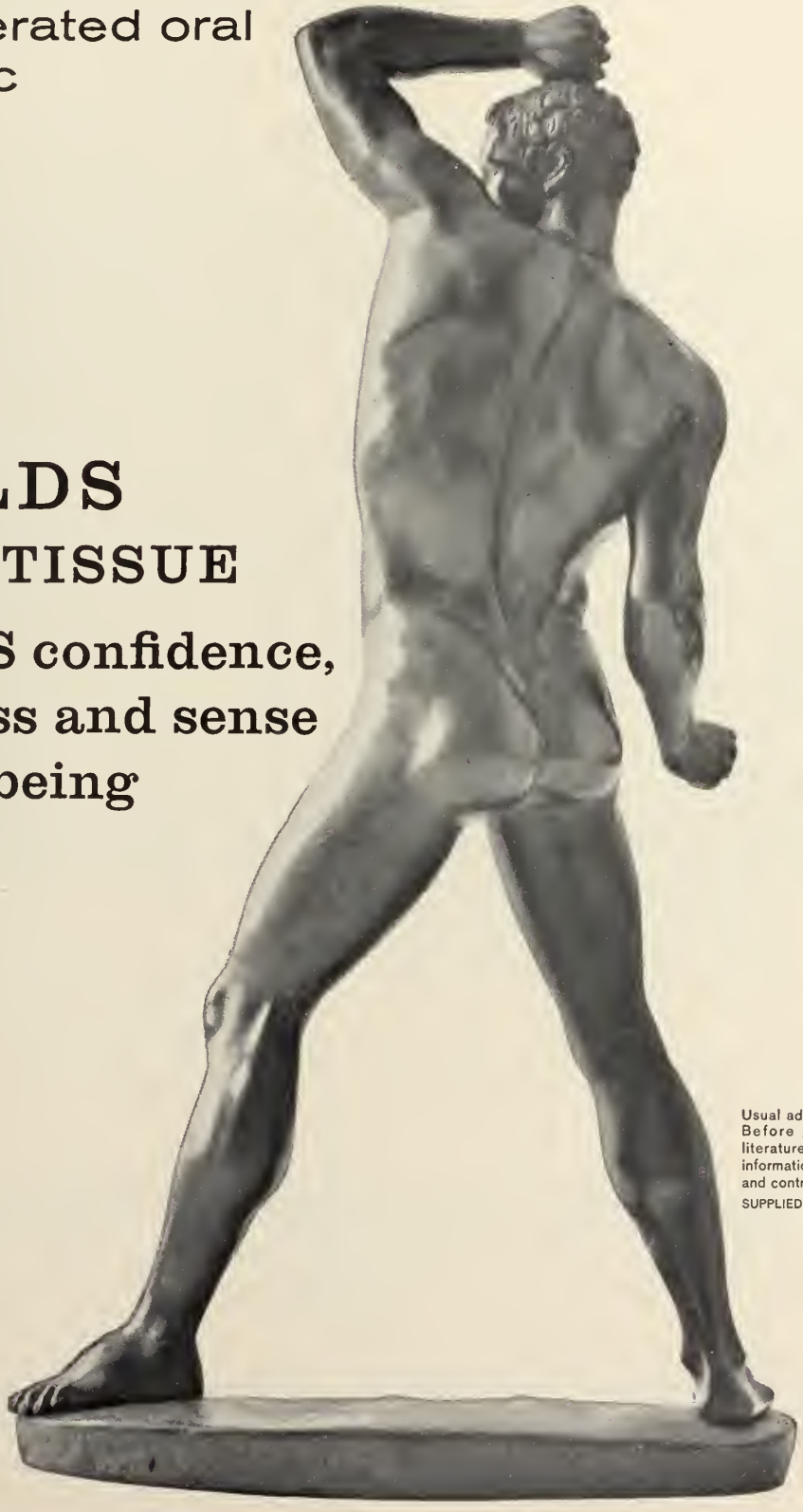
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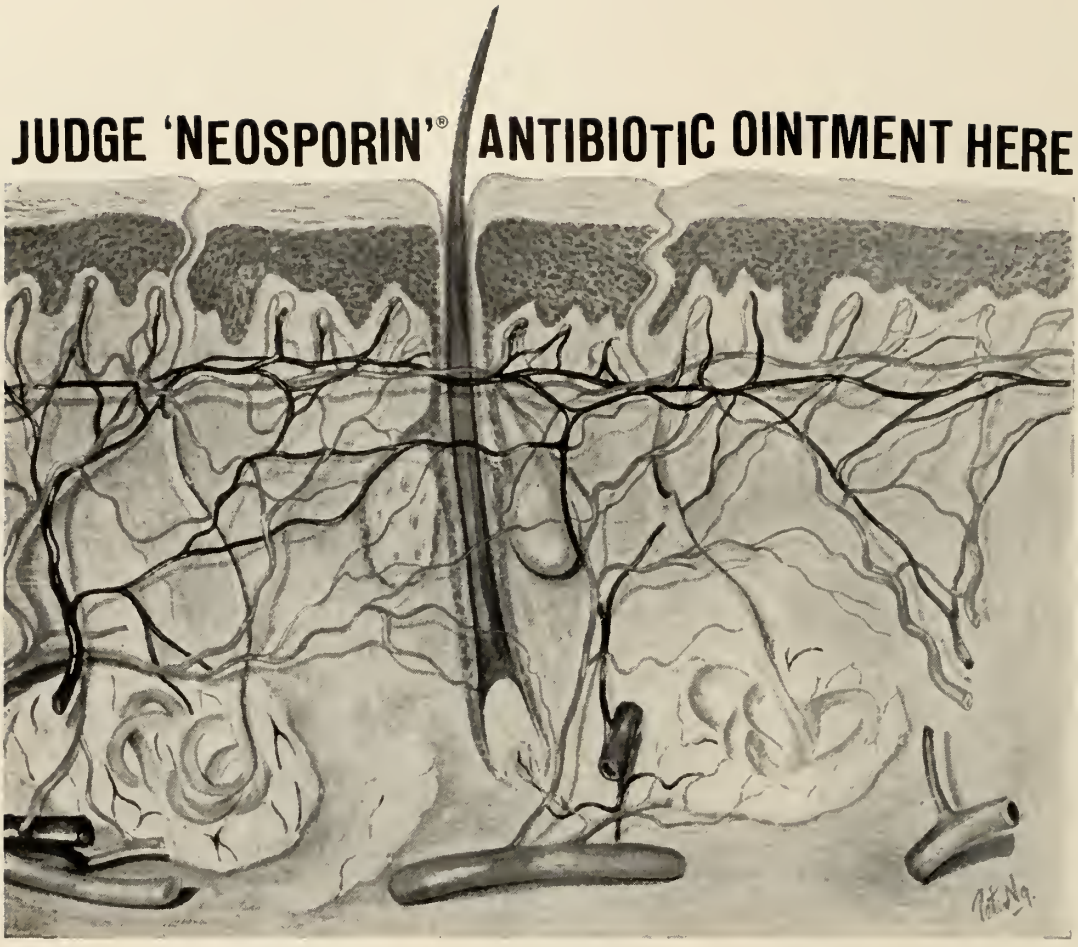
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Anyone who has ever taken a manual blood cell count knows how tedious it can be. And of course tedium breeds errors. Now, the Sanborn-Frommer Cell Counter makes blood analysis extremely simple — pour the sample, press the lever and within 25 seconds you can read the cell count directly on the panel meter.

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Hematology is a relatively new field for Sanborn instrumentation, but we are serving it with the same skills that are applied in the manufacture of electrocardiographs: the 2-speed Model 100 Viso Cardiette . . . its mobile counterpart the Model 100M Mobile Viso . . . and the compact, fully portable, 18-pound Model 300 Visette. These and all other Sanborn clinical, research and monitoring instruments are designed to dependably provide needed information in its most usable form.



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# What Is a House Call Worth?...

## Reporter Gets Facts on Home Service Charges in Many Fields and Comes Up With Some Interesting Figures

OHIO's doctors will be interested in reading and remembering the facts presented in an article by Ned Stout of the *Columbus Dispatch*, in which Stout points out that many other fees for services rendered are higher than that of the physician, so they can cite the article to the next person who charges that the average fees of most physicians are excessive.

"It's getting to the point that it may cost you more to get the kitchen stove repaired than to have your physician stop by to save your life," comments Stout. He then makes these comparisons:

### Comparisons Made

"Doctors, who make house calls in the Columbus area at fees from $5 to $8, have been known to reflect sadly on their plus nine years of schooling after getting a bill for a midnight plumbing call.

"Home service is big business in Columbus, as everywhere, with an estimated 200,000 service calls made yearly in Franklin County — exclusive of television service calls.

### Not Including Parts

"Independent dealer and factory service shops use several methods of arriving at their service call charge, 'not including parts.'

"One independent stove repair specialist charges service call fees ranging from $6 to $10, depending on the location of the customer's home.

"Another has a call-charge of $3.25 plus a half-hour rate of $3.25, while a third charges a minimum $5 for the first hour of work.

"Plumbers generally charge from $6 to $6.50 per, in the normal working day, with a 'time and a half' fee for work done after 5 P. M.

### TV Service Calls High

"An independent television repair operation reported a minimum service charge of $4.50, but claimed most other repairmen 'are considerably higher.'

"A factory service television repair operation sets a $6.95 service rate and adds a $2.50 charge if the set must be cleaned.

"Service calls on other home appliances — washers, dryers, ironers, water heaters, air conditioners, freezers, refrigerators, etc. — have various rates.

"One company has a minimum $6.50 service charge for the first hour, dropping to $6 for any additional hour.

"Another firm states a $4.50 'arrival-at-your-door' charge plus a $6.40 labor fee. A third sets its rate at '$4.50 for the call plus $1.80 per 15 minutes for labor.'

"One of the larger appliance repair operations found an average of 6.5 to 7 television home repairs completed daily per man and an average 5.5 to 6 home repairs on other appliances completed per serviceman.

### Travel Time Involved

"E. M. Steger, manager of General Electric's factory service operation locally, commented, 'Those of us in the business know that the charges seem high to many customers, but there are a number of factors involved which aren't apparent at first.

" 'We've found that actually our workers are in the home only 53 per cent of their day. The rest of the time is involved in travel.

" 'The labor cost, about $3 per hour, for the serviceman, backing him with a radio communications system, expensive mobile equipment and a substantial inventory of parts needed in appliance repair, results in a very small margin of profit.

### Less Efficient Man

" 'Sometimes we suggest, when we get complaints of the 'he was only here 45 minutes and my bill was $10,' variety that the next time we could send a less efficient man to stay two hours for the same charge. That usually takes care of it.' "

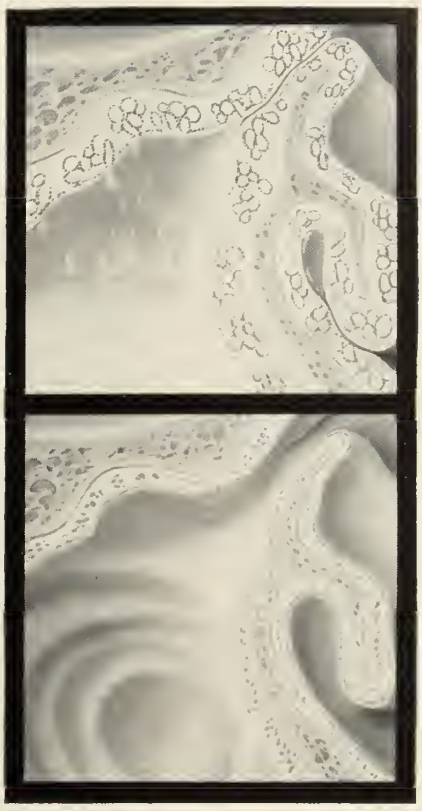
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### Doctors in A. A. Hold Annual Meeting

International Doctors in A. A. held the 15th annual meeting at Moline, Illinois, recently, attended by about 100, including physicians, dentists and guests.

Membership in the organization is open to both physicians and dentists interested in medical or psychiatric aspects of alcoholism and to doctors who are themselves members of Alcoholics Anonymous. The next meeting is scheduled for July 19, 1963 at The Greenbrier, White Sulpher Springs, W. Va. Inquiries should be directed to Lewis K. Reed, M. D., 1950 Volney Road, Youngstown 11, Ohio.

In colds and sinusitis unsurpassed in providing drainage space without chemical harm



**The clogged sinus**
In sinusitis, the mucous membrane becomes hyperemic and edematous, lymph glands and goblet cells hyperactive. Ostium is closed by edema and secretions cannot drain freely.

**The normal sinus**
Magnified anatomy of a portion of maxillary sinus showing mucous membrane with cilia and lymph glands. Ostium is normal and patent.

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hydrochloride

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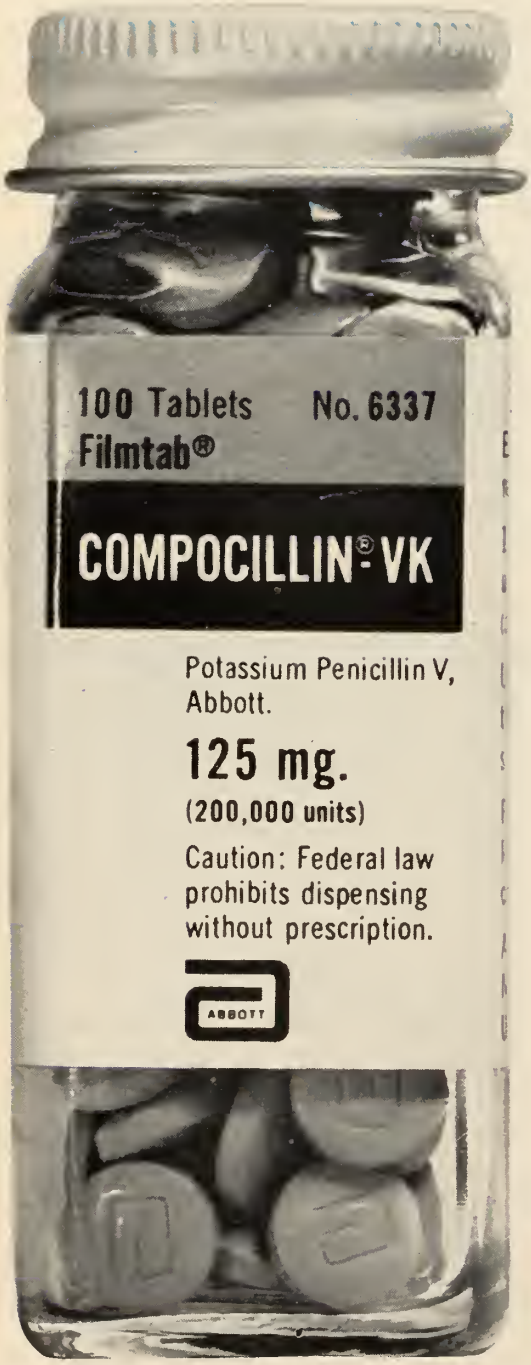
Available in plastic nasal sprays for adults (½%) and children (¼%), in dropper bottles of ⅛, ¼ or 1 per cent.

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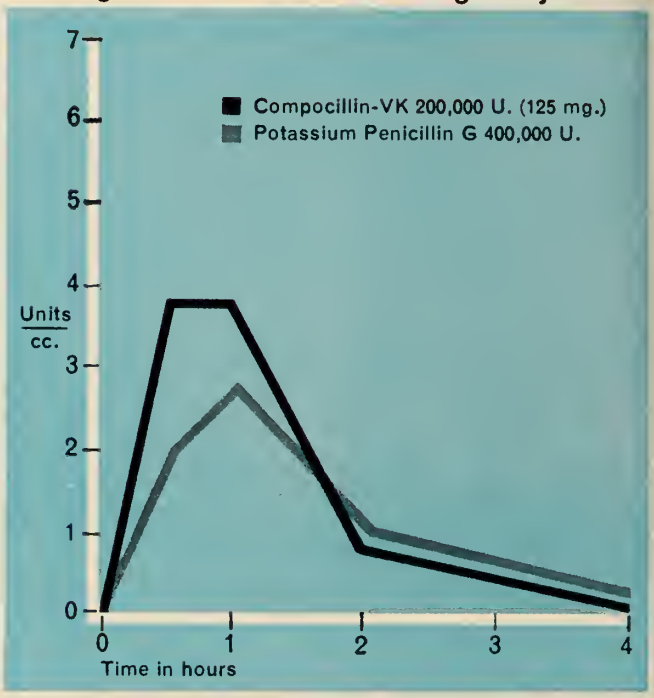
1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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An example might be a respiratory infection. Here economy could be a definite factor in your thinking. In the chart above, you'll see that 200,000 units (125 mg.) of Compocillin VK produces blood levels at least equal to those obtained with 400,000 units of oral penicillin G potassium. This means that in less severe infections, Compocillin-VK may be given at *half* the dosage needed with oral penicillin G—with no sacrifice in blood levels. In these cases, the cost of Compocillin-VK therapy will be no more—and often will be less—than treatment with oral penicillin G.

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Filmtab—Film-sealed tablets, Abbott; U.S. Pat. No. 2,881,085

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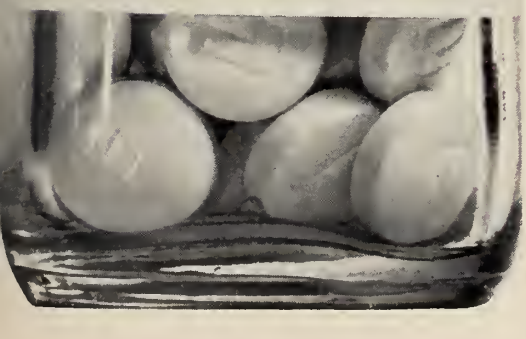



Potassium Penicillin V, Abbott.

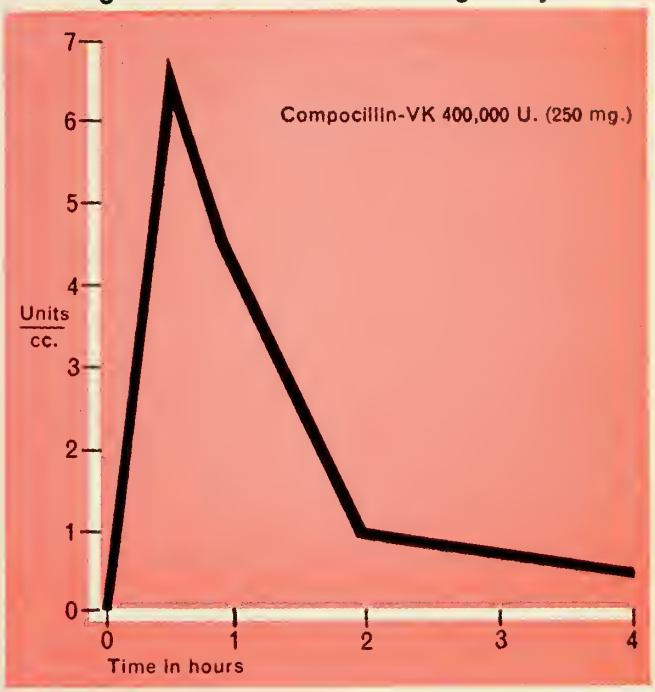
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*Chart data from two separate studies completed by the Microbiologic and Medical Departments of Abbott Laboratories.

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# Evaluation of Renal Biopsy

**Renal Biopsy: Clinical and Pathological Significance**, by G. E. W. Wolstenholme and Margaret P. Cameron, editors for the Ciba Foundation. ($10.50, *Little, Brown and Company, Boston, Massachusetts.)* In this practical symposium 29 pathologists and clinicians critically assess the risks, values, and potentials of percutaneous renal biopsy as an aid to more accurate clinical diagnosis and a guide to therapy.

Arnold Rich of Johns Hopkins University, the chairman of this symposium, made the following observation in his opening remarks: "It is now 10 years since Iversen and Brun published their first 42 successful aspiration biopsies of the kidney, demonstrating the practicality and indicating the reasonable safety of the procedure, both of which have been amply confirmed . . . .

"As would be expected, various questions concerning the clinical and pathological advantages and limitations of the procedure . . . are still not clearly answered. However, in view of the steadily increasing use of this type of renal biopsy . . . it can fairly be said that the clinicopathological significance of renal biopsy is a subject that is ready for profitable examination in a symposium of this type."

**The 20th Century and Your Heart**, by Henry J. Speedby, M. D. ($4.50, *Associated Booksellers, 1582 E. State Street, Westport, Connecticut.)*

**The Integrative Action of the Nervous System**, by Sir Charles Scott Sherrington. ($1.95, *Yale University Press, 143 Elm Street, New Haven, Conn.)*

**Good-Bye, Doctor Roch**, by Andre Soubiran. ($4.50, *Doubleday & Company, Inc., New York 22, New York.)*

**A Synopsis of Public Health and Social Medicine**, by A. J. Essex-Cater, foreword by J. M. Mackintosh, M. D. ($11.00, *The Williams & Wilkins Company, Baltimore 2, Maryland,* exclusive U. S. agents.)

**Vertebral and Carotid Angiograms in Tentorial Herniations**, by Hans F. Plaut, M. D., foreword by Juan M. Taveras, M. D. ($10.50, *Charles C Thomas Publisher, Springfield, Illinois.)*

**Problems of Pulmonary Circulation**; Ciba Foundation Study Group No. 8, by A. V. S. de Reuck, M. Sc., and Maeve O'Connor, B. A. ($2.50, *Little, Brown and Company, Boston 6, Massachusetts.)*

**The Art of Thinking**, by Dagobert D. Runes. ($2.75, *Philosophical Library, Inc., 15 E. 40th St., New York 16, New York.)*

**The Normal Cell and Its Response for Allergic Stimuli**, report of the Thirty-eighth Ross Conference on Pediatric Research, by Ross Laboratories. (Apply, *Ross Laboratories, 625 Cleveland Ave., Columbus, O.)*

**Food and Science . . . Today and Tomorrow**, by William J. Darby, M. D., and Gwen Lam. (25¢, Public Affairs Pamphlet No. 320, *Public Affairs Pamphlets, 22 E. 38th St., New York 16, N. Y.)*

**The Medicine Show**, by the Editors of Consumer Reports. ($1.95 (Paper), $3.95 (Cloth), *Simon and Schuster, Inc., Rockefeller Center, New York 20, New York.)*

**Introduction to Medicine and Medical Terminology**, by Louise Espey Bollo. ($5.00, *W. B. Saunders Company, Philadelphia 5, Pa.)*

**The Annual Survey of Psychoanalysis**, by John Frosch, M. D., and Nathaniel Ross, M. D. ($12.00, Volume 6, *International Universities Press, New York 11, New York.)*

**The Fixed Eruption**, by Ashton L. Welsh, M. D., assistant professor of Dermatology and Syphilology, University of Cincinnati College of Medicine, Cincinnati, Ohio. ($9.75, *Charles C Thomas Publisher, Springfield, Illinois.)*

**Somatic Stability in the Newly Born**: Ciba Foundation Symposium, by G. E. W. Wolstenholme, O. B. E., and Maeve O'Connor, B. A., editors for the Ciba Foundation. ($10.00, *Little, Brown and Company, Boston 6, Massachusetts.)*

**Progesterone and the Defence Mechanism of Pregnancy**: Ciba Foundation Study Group No. 9, by G. E. W. Wolstenholme, O. B. E., and Margaret P. Cameron, M. A. ($2.50, *Little, Brown and Company, Boston 6, Massachusetts.)*

**You and Your Child's School**: Public Affairs Pamphlet No. 321, by Ernest Osborne. (25¢, *Public Affairs Pamphlets, 22 E. 38th Street, New York 16, New York.)*

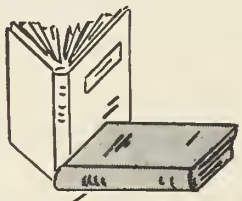
**Chemotherapy of Tuberculosis**, by William F. Russell, Jr., M. D., and Gardner Middlebrook, M. D. ($6.50, *Charles C Thomas Publisher, Springfield, Ill.)*

**Health Insurance**, by Edwin J. Faulkner. ($8.75, *The Blakiston Division, McGraw-Hill Book Company, Inc., New York 36, New York.)*

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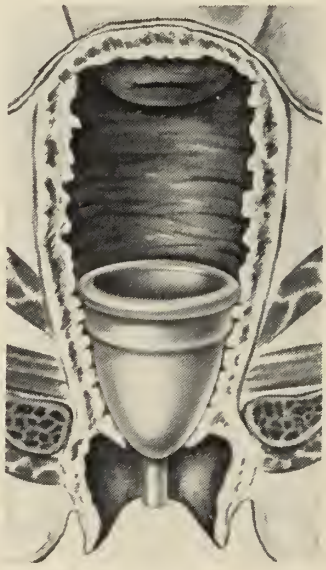
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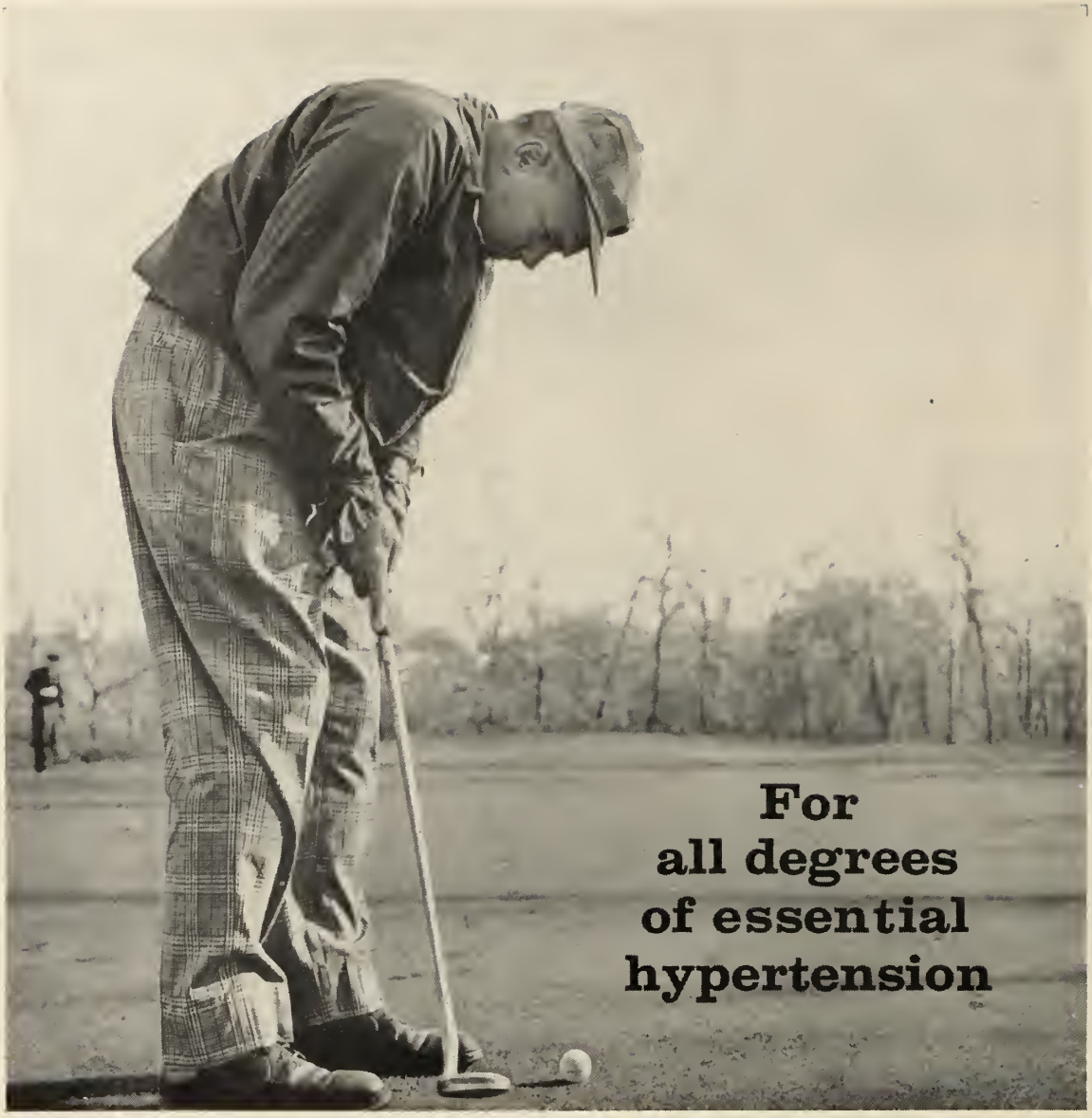
*Ref:* Pena, E.F., Obst. & Gynec., *19:*794, 1962. Karnaky, K.J., Obst. & Gynec., *19:*688, 1962. Pena, E.F., Obst. & Gynec., *19:*684, 1962. Karnaky, K.J., Tri-State M.J. Sept., 1961. Burrus, S. Jr., Am. J. Obst. & Gynec. *80:*390, 1960. Karnaky, K.J., Tri-State M.J. Aug. 1960. Karnaky, K.J., Tri-State M.J., June, 1960. Liswood, R., Cur. Med. Dig., *26:*92, 1959. Schaefer, G., Clin. Obst. & Gynec., *2:*535, 1959. Liswood, R., Obst. & Gynec., *13:*539, 1959. Dickinson, R.L., JAMA, *128:*490 (June 16) 1945. Biskind, Mod. Med., *22:*128 (June 15) 1954.




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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

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1. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No. 2, February, 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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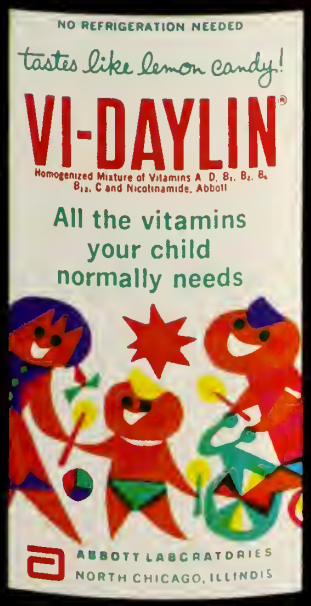
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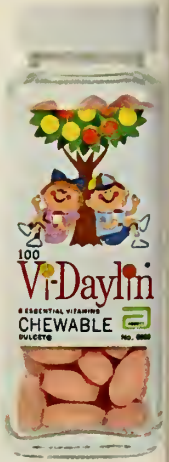
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**Available:** Bottles of 100 tablets.

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**Clinical background?** This steroid has a recorded history unequaled in scope and authoritativeness among all the newer corticoids. **Quality?** HEXADROL, brand of dexamethasone 'Organon'...your assurance of professional quality through research, production and control. **Dosage flexibility?** Tablets 0.75 mg. and new strength 0.5 mg., plus new form, Elixir (0.5 mg. per 5 ml.) now available to meet prescription needs.

**Cost-to-patient?** Greatly reduced! Why not check with your local pharmacist on prescription cost to your patients?

Organon

asthma attack averted
**. . . in minutes**

patient protected
**. . . for hours**





# Nephenalin®

(the dual-action anti-asthmatic tablet)

**. . . works with nebulizer speed—provides four-hour protection**

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, 3/8 gr.; phenobarbital, 1/8 gr.

**Dosage:** Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

**Supplied:** Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

**Caution:** Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.



# Put your low-back patient back on the payroll

*Soma relieves stiffness —stops pain, too*

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

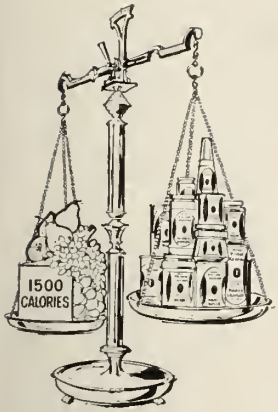
Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

*The muscle relaxant with an independent pain-relievin*

SOMA

*(carisoprodol,*

Wallace Laboratories, Cranbury, New




# How to get patients to follow your directions for weight control...easily

## 60 DELICIOUS FOODS THAT CUT CALORIES, FAT AND CARBOHYDRATES!

**How often** do you sit across the desk from a patient whose problem is overweight, and wonder whether the directions you give for diet will be followed accurately—or at all?

**A pleasant and efficient solution** to this problem is to recommend the new Mott's Figure Control Foods. This line of over 60 different items has been developed through the latest scientific knowledge in the field of nutrition—and provides foods lower in calories by an average of 50%. Figure Control Foods take the guesswork out of menu-planning. Calorie cutting can be made pleasant and accurate, while eating normal-size portions of the kinds of food people enjoy every day at breakfast, lunch and dinner.

**Low carbohydrate, low fat:** Meat products have most of the hard fats removed (these are the saturated type) in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids; all are delicious and appetizing. Fruits, juices, desserts and sauces are prepared with non-caloric sweetener—natural fruit values are intact.

The carbohydrate, protein and fat content appears on each label, along with calorie counts. Useful for diabetics, too.

**Easy medical tool for doctors:** No possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods in supermarkets include: Soups, Meats, Poultry, Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts, Sweeteners.

### New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

| | Quantity | Figure Control Calories | "Regular" Food Calories |
|---|---|---|---|
| Apple-Grape Drink | ½ cup | 20 | 52 |
| Five-Fruit Juice Breakfast Drink | ½ cup | 20 | 52 |
| Braised Beef and Vegetables | 6½ oz. | 184 | 380 |
| Meat Balls in Brown Gravy | 3½ oz. | 84 | 280 |
| Chopped Chicken Livers | 1 oz. | 31 | 100 |
| Chicken a la King | 3 oz. | 72 | 230 |
| French Style Dressing | 1 tbsp. | 10½ | 60 |
| Brown Gravy | 1 tbsp. | 7 | 21 |

| | Quantity | Figure Control Calories | "Regular" Food Calories |
|---|---|---|---|
| Applesauce | ½ cup | 48 | 90 |
| Fruit Cocktail | ½ cup | 44 | 90 |
| Cherry Pie Filling | 1 oz. | 20 | 60 |
| Chocolate Topping | 1 tbsp. | 8 | 63 |
| Preserves (Peach, Strawberry) | 1 tbsp. | 9 | 55 |
| "Maplette" Syrup | 1 tbsp. | 9 | 55 |
| Liquid or Powder Sweetener | (to equal 1 tbsp. of sugar) | 0 | 16 |




**Complete menus, recipes, calorie chart** available for professional distribution, with weight control guides you can distribute with confidence: all menus meet N.R.C. Recommended Daily Allowances. **Use this handy order form:**

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NEW **SPECIAL COUGH FORMULA** *for Children*

# Pediacof

Trademark

**SOOTHING DECONGESTANT AND EXPECTORANT**

**Each teaspoon (5 cc.) contains:**

| | |
|---|---|
| Codeine phosphate | 5.0 mg. |
| Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) | 2.5 mg. |
| Chlorpheniramine maleate | 0.75 mg. |
| Potassium iodide | 75.0 mg. |



***Bright red, pleasant tasting, raspberry flavored syrup***

**Dosage:**

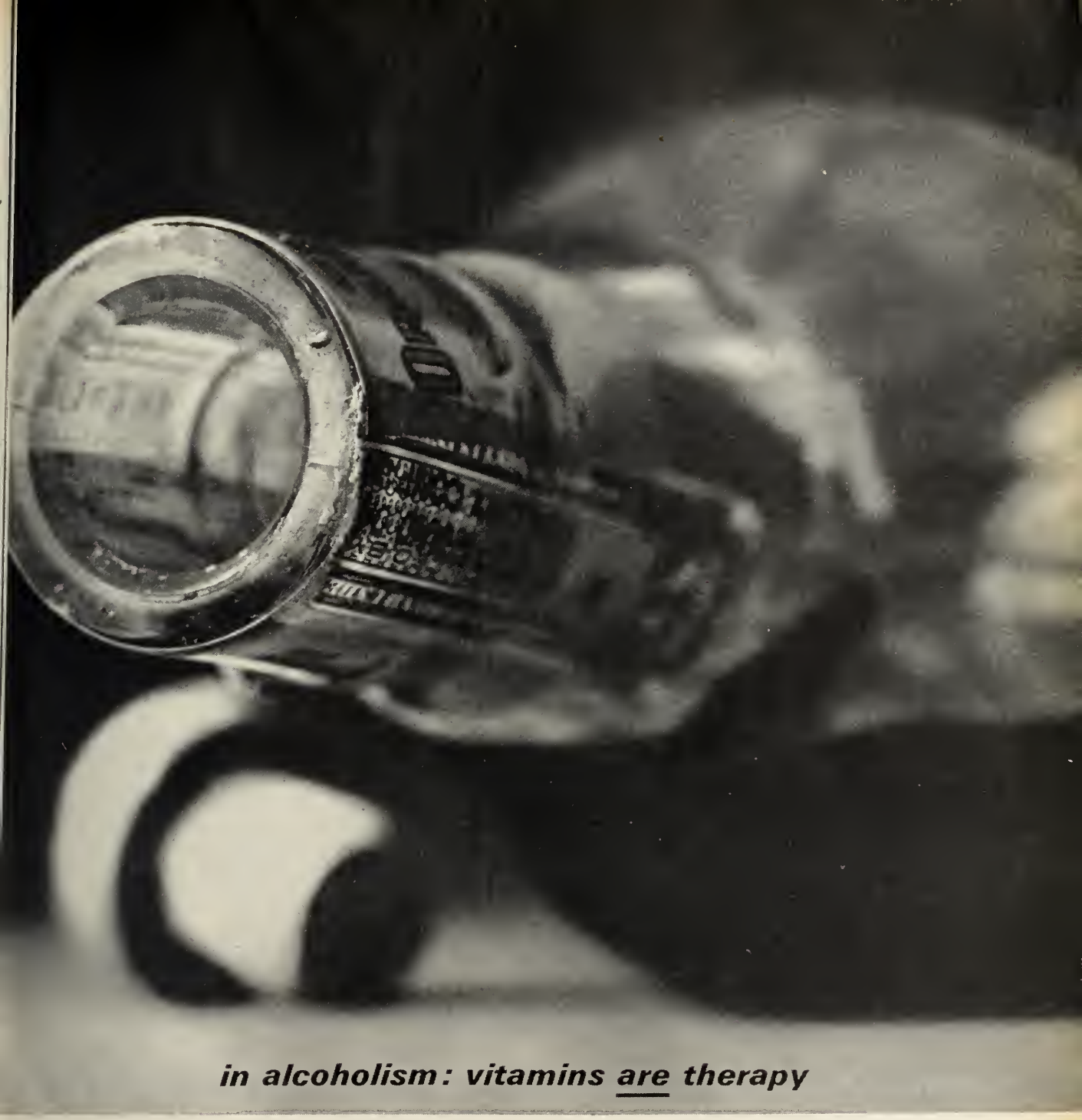
Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

**How Supplied:**
Bottles of 16 fl. oz.

**Exempt Narcotic**

Winthrop
LABORATORIES
New York 18, N. Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.



***in alcoholism: vitamins are therapy***

A full "comeback" for the alcoholic is partly dependent on nutritional balance...aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished...from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins. Supplied in decorative "reminder" jars of 30 and 100.

| Each capsule contains: | |
|---|---|
| Vitamin $B_1$ (Thiamine Mononitrate) | 10 mg. |
| Vitamin $B_2$ (Riboflavin) | 10 mg. |
| Niacinamide | 100 mg. |
| Vitamin C (Ascorbic Acid) | 300 mg. |
| Vitamin $B_6$ (Pyridoxine HCl) | 2 mg. |
| Vitamin $B_{12}$ Crystalline | 4 mcgm. |
| Calcium Pantothenate | 20 mg. |

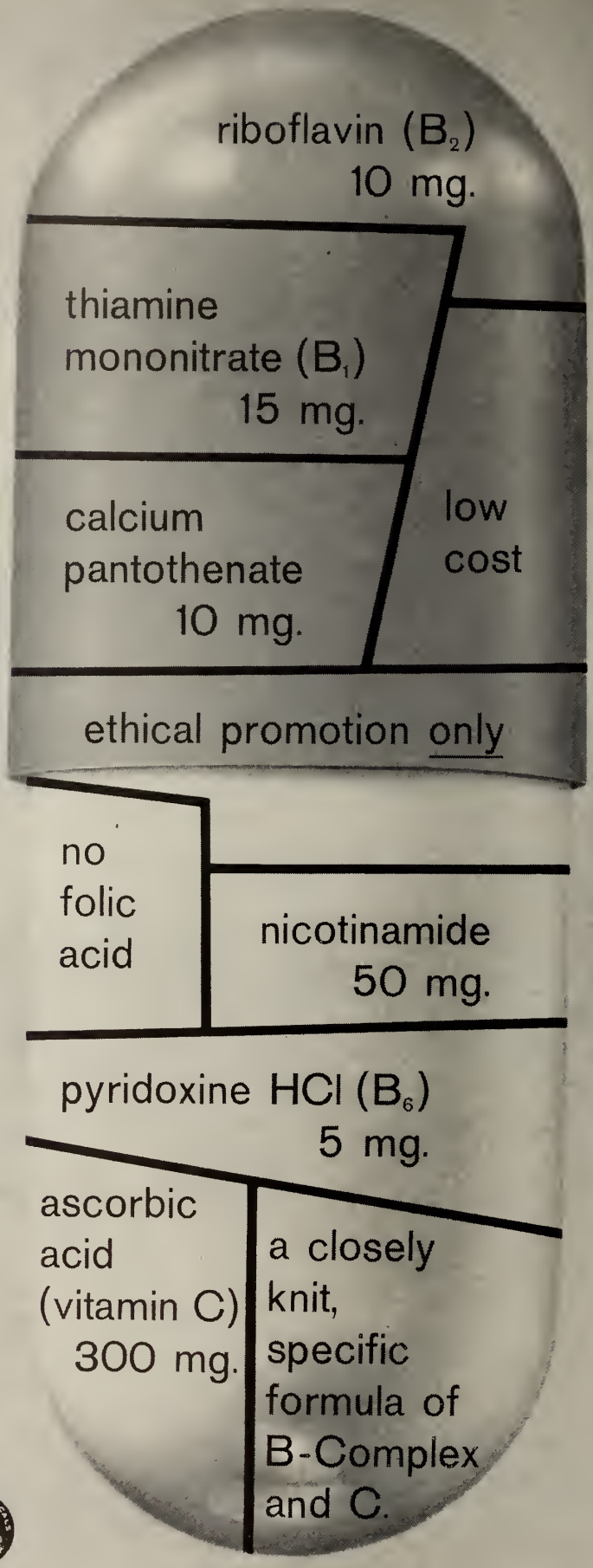
Recommended intake: Adults, 1 capsule daily or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

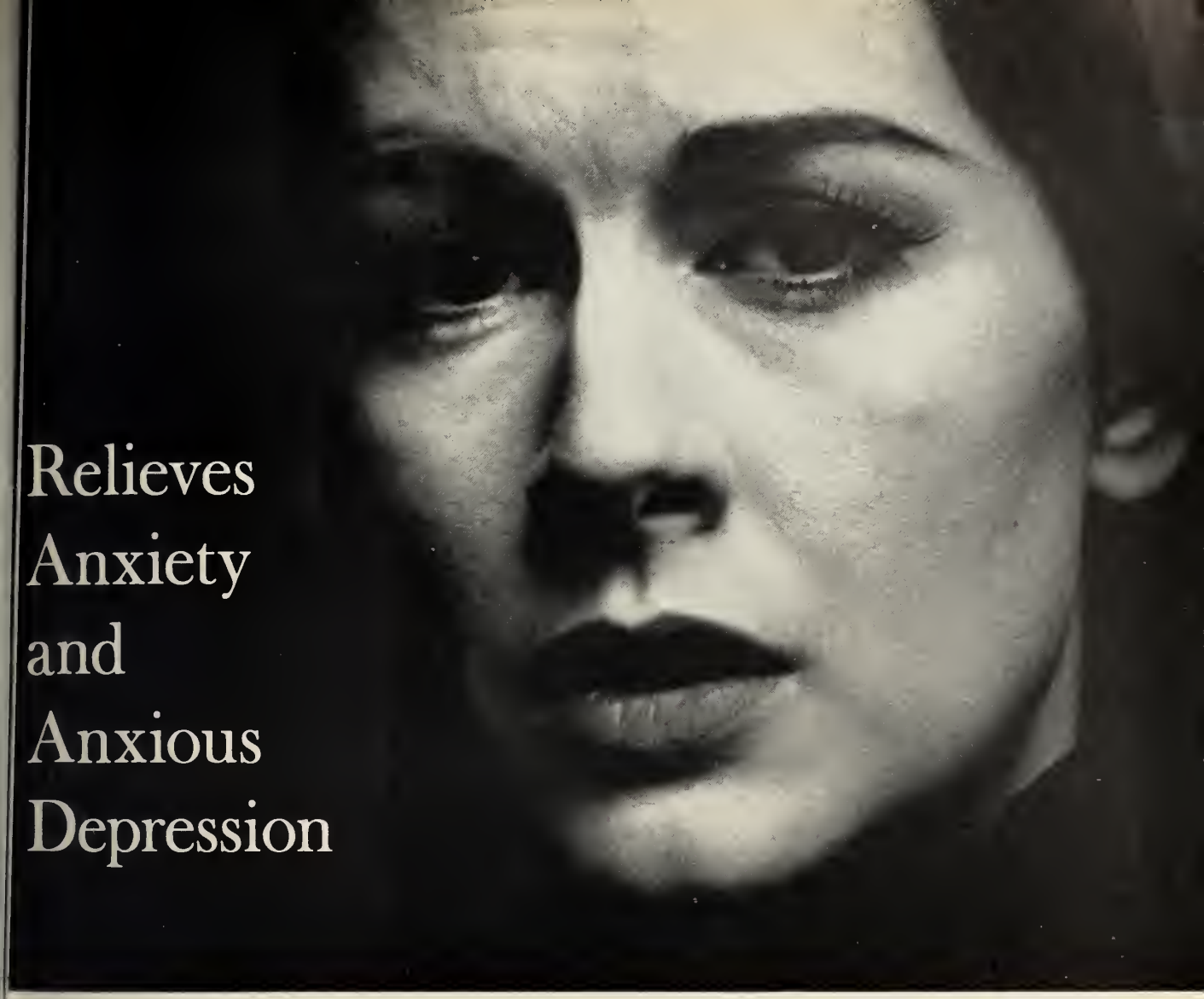
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# this is what Allbee® with C is made of!




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## Miltown®

meprobamate (Wallace)

***Usual dosage:*** One or two 400 mg. tablets t.i.d.
***Supplied:*** 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® — 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES / *Cranbury, N. J.*

## Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms or liver damage
3. Does not muddle the mind or impair physical activity

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# the right combination



*. . . safe, effective antihypertensive therapy*

# Rauprote

(Rauwolfia serpentina and Protoveratrines A and B combined)

Rauprote combines two effective antihypertensive agents—*Rauwolfia serpentina* for moderate tranquillizing and gentle hypotensive effect, and Protoveratrines A and B for faster, more potent lowering of blood pressure and bradycrotic action. The combination produces a therapeutic hypotensive effect which is superior to larger doses of either drug alone; reduced dosage of both components minimizes or eliminates toxic side effects completely.[1,2]

Clinical studies show the majority of patients suffering from significant elevation of blood pressure achieve an excellent response to this combination.[2]

Rauprote is indicated in management of moderate to severe essential hypertension.

**Supplied:**

In bottles of 100 and 1,000 tablets, each tablet containing 50 mg. *Rauwolfia serpentina* and 0.2 mg. Protoveratrines A and B (alkaloids of *Veratrum album*).

1. Goodman, L.S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., Macmillan & Co., New York (1955).

2. Roberts, E.: Four Year Evaluation of an Antihypertensive Agent, J. Am. Med. Women's Assn. *13*:349 (1958).

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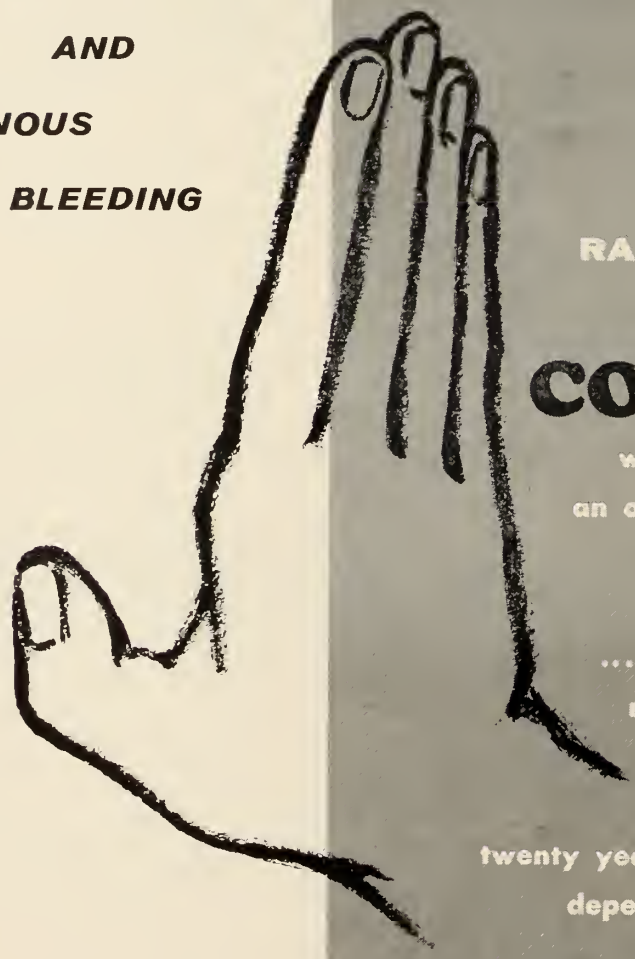
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*an aqueous solution of oxalic and malonic acids*

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"Does it help the patient maintain the proper diet, is it free of dangerous side effects, and does the patient like it?"[1]

Perhaps you'll find, as Stevenson did, "['Eskatrol'] seems to meet these criteria better than most."

1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



# ESKATROL® SPANSULE®

brand of sustained release capsules

PRESCRIBING INFORMATION

**Formula:** Each 'Eskatrol' *Spansule* sustained release capsule contains Dexedrine® (brand of dextro amphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the dimaleate.

**Recommended Dosage:** One 'Eskatrol' *Spansule* capsule daily, taken in the morning.

**Side Effects:** Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

**Cautions:** Clinical experience has demonstrated that 'Eskatrol' (containing the phenothiazine derivative, prochlorperazine) has a wide margin of safety and that there is little likelihood of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms). The physician should be aware, however, of their possible occurrence.

'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability.

Prescribing information adopted Jan. 1961

**Smith Kline & French Laboratories** SK&F

# In intestinal "grippe"

prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis



# POMALIN

TRADEMARK

Liquid

**EFFECTIVE ANTIDIARRHEAL**

**FORMULA:** *Each 15 cc. (tablespoon) contains:*

| | |
|---|---|
| Sulfaguanidine U.S.P. | 2 Gm. |
| Pectin N.F. | 225 mg. |
| Kaolin | 3 Gm. |
| Opium tincture U.S.P. | 0.08 cc. |
| (equivalent to 2 cc. paregoric) | |

**DOSAGE:** Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

**SUPPLIED:** *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
*Exempt Narcotic. Available on Prescription Only.*

Winthrop LABORATORIES
New York 18, N. Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.



# Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

| Location | Facility | Telephone |
|---|---|---|
| Akron | Children's Hospital<br>W. Bowery and W. Bechtel | BL 3-5531, Ext. 246 |
| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
| Toledo | Toledo Health Department<br>635 N. Erie St. | CH 4-1961—(Day)<br>EV 5-4661—(Night) |
| Youngstown | Emergency Room Dept.<br>St. Elizabeth Hospital<br>1044 Belmont Street | RI 6-7231, Ext. 220 |


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An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation. There are ample facilities for classification of patients

**Insulin coma, electroshock, psychotherapy, occupational and recreational therapy are employed. The hospital is equipped with complete laboratory facilities, including electroencephalography and x-ray.**

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your
OVER-
WEIGHT
PATIENTS
with
OBETROL
for medical management of obesity



# OBETROL

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The DIFFERENT amphetamine combination of choice . . . **OBETROL** incorporates the desired action of amphetamines with fewer side reactions reported.

- **Clinically evaluated**
- **Allays hunger**
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- **Elevates mood**
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"In the cooperative patient, (OBETROL) was markedly beneficial in producing the desirable weight loss with minimal side effects, even in the case of a high percentage of patients with cardiovascular and other chronic ailments which normally make use of other amphetamines undesirable because of side effects" [1 3]

### WEIGHT REDUCTION EFFECTIVE IN DIFFICULT CASES

"In a group of 100 patients, of whom 60 had diabetes, arteriosclerosis, hypertension, or a combination thereof, we were able to get weight reduction, using (OBETROL) and diet . . . With a daily divided dosage of 30 milligrams of (OBETROL) we were able to obtain appetite depression without nervous restlessness or insomnia . . ."

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Twenty six patients who previously had been unable to use other amphetamines in any dosage sufficient to maintain the anorectic effect, responded favorably on this medication.[1 3]

OBETROL is available in 10 mg. and 20 mg. tablets in bottles of 100, 500, and 1,000.

Trademark. A unique combination of equal parts of Methamphetamine Saccharate, Methamphetamine Hydrochloride, Amphetamine Sulfate and Dextroamphetamine Sulfate. Pat. #2748052

## OBETROL PHARMACEUTICALS

382 Schenck Avenue, Brooklyn 7, N. Y.


[1] Simon, F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, *12*:32-37, Jan. 1961.
[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
[3] Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.


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DRINK Coca-Cola TRADE-MARK ®



# from boutonneuse fever in Afric

Whether treating boutonneuse fever, bronchopneumonia, or a host of other infections, physicians throughout the world continue to rely on the effectiveness, relative safety, and exceptional toleration of Terramycin in broad-spectrum antibiotic therapy. This continuing confidence is based upon thousands of published clinical reports and successful experience in millions of patients. *The next infection you see will more than likely be "Terra-responsive."*



**IN BRIEF** The dependability of Terramycin in daily practice is based upon its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using.

*More detailed professional information available on request.*

---

**Boutonneuse fever** is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

# o bronchopneumonia in Ohio

BRAND OF OXYTETRACYCLINE

**Terramycin®** capsules • syrup • pediatric drops
intramuscular solution • intravenous

lso available with nystatin as TERRASTATIN® (capsules and oral suspension)

# History of the Lakeside Unit Of World War I

HARRY D. PIERCY, M.D.*

## Part VI

*(Concluded from September Issue)*

TIME hung somewhat heavy on us from now on. For the first time the officers were given drill for two hours five days each week. By the end of February we could dress a fairly good straight line and we had acquired the necessary reflexes to smoothly follow commands. There were no regrets when this routine was discontinued sometime in early March.

### Farewell Dinner

On February 22 the officers' mess gave the farewell dinner to our British friends and liaison officers. Mr. and Mrs. Reitenbach. Miss Falckemer, Miss Engle, Miss Taylor, Miss Schnaitter, also Wm. J. Brownlow, were among the invited guests. There was a long toast list headed by Col. Bunts toasting George Washington and ending with Brownlow toasting the ladies. Then we all drank a deep, deep toast to those at home.

Early in March a letter from Emile Blondel to Colonel Bunts was received. This bore the letterhead, *The Association of French Homes*. I quote in part its sincere statements:

> "My fellow citizens have wished to do me the great honor of placing me at the head of the association of "French Homes" in order to show the representatives of the United States our entire admiration as well as our full recognition of their invaluable co-operation. It is also our mission at the same time to make you acquainted with French family life.
>
> "Our literature, our modern theatre, above all, the high life of Paris have unfortunately given to the stranger an imperfect conception of this life.
>
> "You, my dear Colonel, and your friends who have dwelt intimately with us for a few weeks, you, who have known our thoughts and our pleasures may at least have a more correct conception of our family life.
>
> "We desired to replace for a moment your absent fireside, the home to which you will soon return to receive the welcome which awaits the absent and conquerors.
>
> "These happy meetings have truly made the world seem smaller, let us hope they will help to make it better."

### Nurses Start for Home

Our Nurses left us in groups of 20 or so at a time, from February 17, 1919, and assembled at Base Hospital 136 for about three weeks. They then moved on to Brest and sailed from there on March 22 on the United Fruit Ship, *Heredia*. They landed in Hoboken on April 3, 1919.

### Homeward Bound

The Officers and Enlisted Men broke camp on March 8, 1919, and went by troop train to Vanne. We remained there 10 days and then moved on to Brest and Camp Poutanezen from which on April 1 we boarded the *U. S. S. Agamemnon*, a huge vessel choaked with troops of the Twenty-first Division. Arriving in Boston harbor on April 7, there was an escorting fleet of submarine chasers surrounding us. There was a din of boat and tugboat whistles, and a large yacht with a brass band aboard playing against this noisy competition. The newspapermen who came aboard, shortly after the pilot, got around to our officers and, observing our four service stripes, asked when we had arrived in France. When we informed them that we were the first "over there" they refused to believe it. However, why should our small organization receive much of their credence of time? The noisy and enthusiastic reception was for the New England Twenty-first Division, which returned full of honors and hung with decorations.

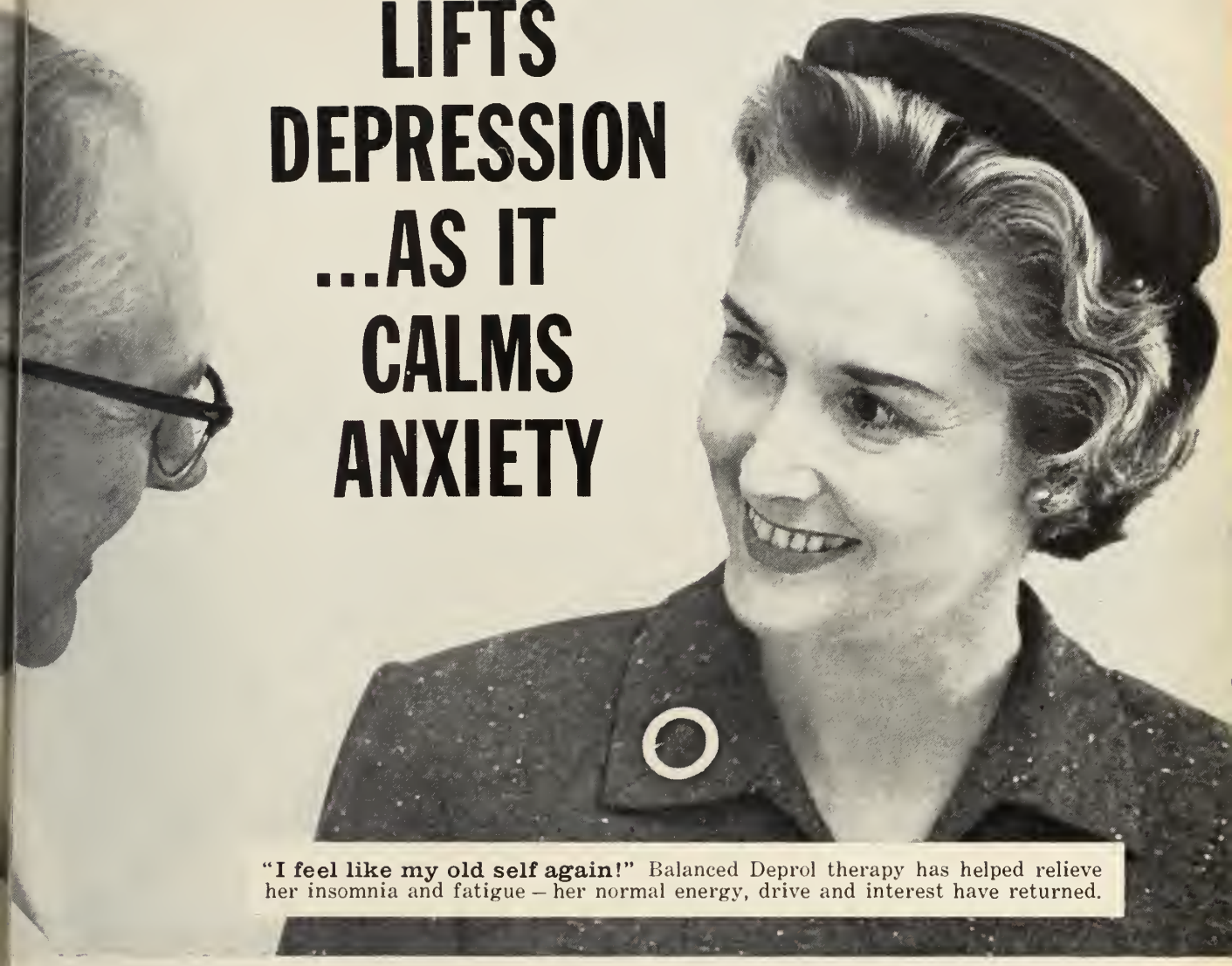
We took a train out to Camp Devens. All along the way the homes and factories were decorated with flags and bunting and crowds were cheering. Every locomotive we passed saluted this succession of 12 trains taking us and the Twenty-first Division out to the Casual Camp. The YMCA passed through the cars handing out magazines, postal cards and candy. We spent five restless and impatient days at Camp Devens and on the 13th of April we entrained for Camp Sherman, Chillicothe, Ohio. At last the Lakeside Unit was home.

### Resumption of Civilian Life

The Base Hospitals that were loaned or assigned to the British had been organized by the civilian hospitals in our various cities. Their personnel was enlisted locally and these units were popularly known

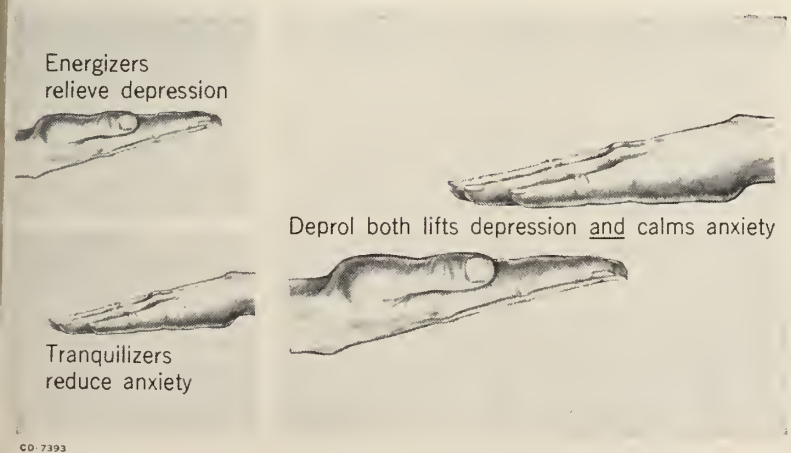
*Dr. Piercy, Cleveland, is a member of the courtesy staffs of University Hospitals, and St. Luke's Hospital, Cleveland, Ohio.
Submitted June 23, 1961.

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as the Lakeside, the Harvard, the Chicago, the St. Louis, etc., units. The St. Louis Unit, Base Hospital No. 12 was located on the route d' Elbouf about two miles below us. When returned to the USA these units came back to the cities of their origin. This was the experience of the Lakeside Unit. It had not been broken up or dispersed or moved from site to site during the period of active duty. The members of our unit had been through a hard and demanding cooperative effort; through experiences both grave and gay. We had shared in the great adventure of our time. This experience being common to all of us it was natural that each member would feel an attachment to the group, which has carried over even to today. Since 1919, the Nurses, the Enlisted Men and the Officers have had annual reunions of their respective ranks.

### "Old Soldiers Fade Away"

There are only 12 surviving officers of our roster of 43. Three of these reside in Cleveland; the others are scattered between Philadelphia and Pasadena. The Nurses and the Enlisted Men experience an accelerating diminution in membership, as these years pass swiftly by. Their members are spread widely over the United States and a few are beyond its borders. A surprising number of the distant ones occasionally will return to the annual reunions.

On two occasions we have had reunions of all our command, nurses, enlisted men and officers. These were held on the tenth and the twenty-fifth anniversaries. On these occasions the wives and husbands, as the case might be, of our personnel got acquainted with the comrades and friends of their mates during the stirring days of the First World War. Charles R. Couch keeps a current record of the Enlisted Men and Ida F. Preston, who now resides in Florida, keeps a biographical record of the Nurses and gets out an annual mimeographed report which is sent to all their members.

### Vital Statistics

In concluding this account, something should be said about the state of health of this Unit while overseas. There were no serious illnesses. During November and December 1917 and January 1918 there occurred an epidemic of mild influenza which pervaded all ranks. The morbidity was slight and I doubt if more than 10 per cent of our command were affected. After the Armistice, there occurred the pandemic of virulent influenza (flu). It spread rapidly through the British Army and throughout the whole Hospital Base in Rouen. The personnel of the surrounding hospitals were sorely stricken and many cases ended fatally in a few days. The St. Louis Unit lost several nurses and, as I recall, one or two officers.

Though we had many of these patients on our wards, no one in our command was stricken with this form of flu. The epidemic was over in a few weeks. It was concluded that the mild flu prevalent the previous year had immunized us and protected us from the virulent epidemic. It was a matter of great satisfaction tempered by a deep feeling of gratefulness that of our command of 510 persons, every nurse, enlisted man and officer attached to the Lakeside Unit returned home.

### Conclusion

This account of our experiences in the period of 1917 to 1919 may provoke a mood of nostalgia in those who remember that this "War was fought to end all Wars," and who recall that its purpose was to make the "world," however unready, "safe for democracy." These slogans seem juvenile and unrealistic after all that has happened in the past quarter of a century. They were, however, coined by an idealist as expressing the best hope for an exhausted and war-weary world.

As for the members of this Unit, the prolonged residence in a foreign land, the need for harmonious cooperation of all ranks under a common rule of discipline, the contact with patients from every country in the British Empire, and toward the end, the delightful welcome given them in the French homes, proved to be a broadening experience, enriching their lives and giving them reason to feel proud and grateful for the opportunity they had to share in this military adventure.

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Personal Diary of the Author.


## First Successful Blood Transfusion Is Commemorated by Plaque

Cleveland—Between 75 and 100 persons gathered at St. Alexis Hospital recently to witness the dedication of a plaque memoralizing the first successful blood transfusion in recorded medical history which took place at St. Alexis on August 8, 1906. The transfusion was performed by Dr. George W. Crile, then on the St. Alexis staff. — *Garfield Heights Tribune.*

## History Written on Hardin County Medical Society

A series of articles on the history of the Hardin County Medical Society started in the May 8, 1962 issue of the *Kenton Times*. Written by Herbert T. O. Blue, the series traces the history of the Hardin County Medical Society from its organization in 1850. Subsequent articles were published on pioneer physicians of the area.

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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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Scientific Section

VOL. 58 OCTOBER, 1962 NO. 10

# Assisted Circulation

## Continuation of Coronary Symposium

ARMAND A. LEFEMINE, M.D., and DWIGHT E. HARKEN, M.D.

EXTRACORPOREAL mechanical assistance for the heart in failure promises a means of saving many of the patients who do not respond to medical treatment. It may enable us to tide a patient over an otherwise fatal coronary occlusion, to offer direct assistance by reduction of myocardial oxygen requirements, or to sustain life until corrective surgery can be carried out.

There are three general forms of assisting the circulation; the first involves transfer of blood from the venous to the arterial compartment, the second is limited to the arterial side alone, and the third is limited to the venous side. The first two techniques may be synchronized with the patient's heart action. Of these the conventional form is *non-synchronized veno-arterial bypass* consisting of diverting a portion of the venous blood through an extracorporeal pump-oxygenator to the femoral artery. This reduces cardiac output and elevates mean aortic pressure.[1] *Flow work* of the heart is reduced and coronary circulation increased by elevating the mean aortic pressure.[2] A conspicuous disadvantage lies in the increase of cardiac pressure work which requires approximately ten times as much oxygen as flow work.[3,4] The second method is designed to alter *pressure work* of the heart by using a piston pump so synchronized with the electrocardiographic R wave that the pump aspirates from the arterial compartment during systole and returns the same stroke volume during diastole when the left ventricle is at rest and isolated by a closed aortic valve. We describe this as *arterial synchronized counterpulsation*.[5] Essentially this produces a reversal of the normal aortic pressure contours reducing systolic pressure and elevating diastolic pressure. The theoretic change is illustrated. (Fig. 1.) The chief advantages are a reduction of left ventricular pressure and tension corresponding to the reduction of systolic pressure and an increase in coronary flow by greater diastolic perfusing pressure. This is accomplished through a single intra-arterial cannula. The third form of assisted circulation is primarily pulmonary assistance whereby venous blood, generally from the femoral vein, is passed through an oxygenator and returned via the subclavian vein or superior vena cava.

Selection of the method must be dictated by the physiologic need. The lung in pulmonary edema

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From the Department of Surgery, Peter Bent Brigham Hospital and Surgical Research Laboratory, Harvard Medical School. Supported in part by USPHS Grants H-2419 and HTS-5231.

Presented before The Cleveland Area Heart Society Eleventh Annual Meeting, November 30, 1960, Cleveland, Ohio.

may prove to respond better to reduced flow; the myocardium may be assisted more by reduced pressure work; and emphysematous lungs in failure may benefit most by venous blood oxygenation and venous return.

The problem of flow work versus pressure work as determinants of myocardial oxygen consumption is critical to the application of mechanical assistance to the patient with a coronary thrombosis. Sarnoff and his collaborators[3] have determined myocardial oxygen consumption of pressure work and flow work separately and found that mean systolic pressure and systolic time are the dominant factors determining myocardial oxygen requirements. They found that the *time-tension index,* a product of the mean systolic pressure and the duration of systole per minute, offers the best correlation with myocardial oxygen consumption, a basic measure of myocardial work. In addition to myocardial oxygen consumption, the availability of oxygen as provided by coronary flow is equally important. This is directly related to the mean aortic pressure and more specifically to the disastolic pressure since two thirds of coronary flow occurs during this period.[6] Ideally, optimum myocardial assistance requires a reduction of systolic pressure and time and an increase in diastolic pressure and time. In severe shock the maintenance of an adequate systemic perfusion pressure becomes the prime necessity irrespective of myocardial work.

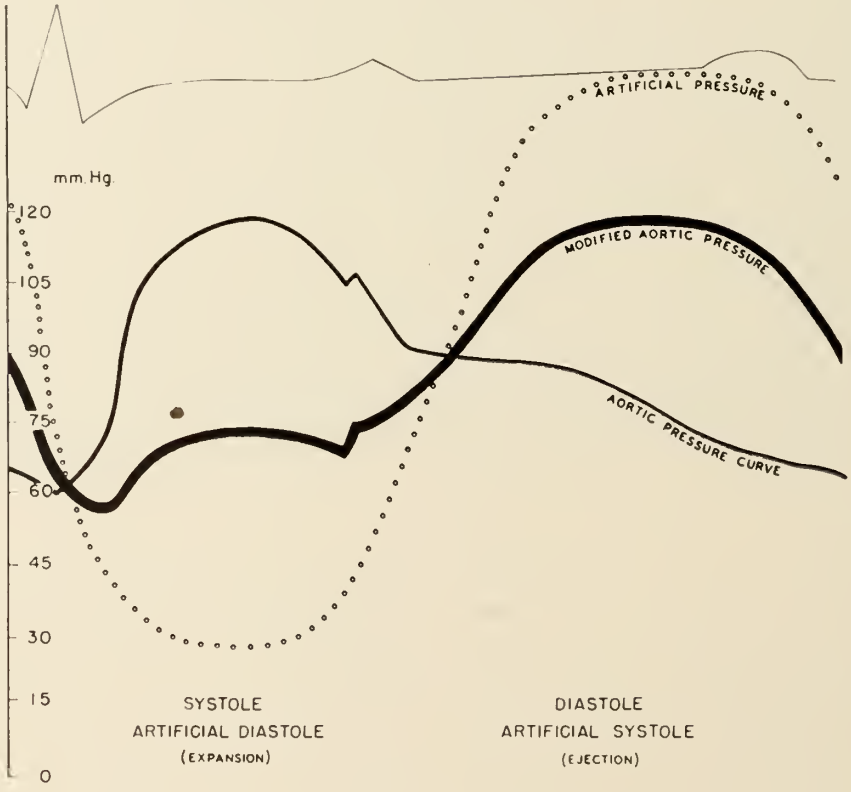
**Coronary Symposium**

This symposium is based upon the outstanding Coronary Artery Day program presented November 30, 1960, by the Cleveland Area Heart Society. Five papers were published in the September issue of *The Journal,* and the three published this month will terminate the symposium.

THE EDITOR.

### Veno-Arterial Pump-Oxygenator Assistance

Veno-arterial bypass has had its most extensive application in support of the failing heart immediately following the intracardiac portion of open heart procedures. It plays a significant role in the recovery from the reversible myocardial failure that often follows prolonged periods of cardiac arrest. The important relationship of mean aortic pressure and coronary flow to electrocardiographic recovery following 30 minutes of anoxic arrest during correc-




MODIFICATION OF THE AORTIC PRESSURE CURVE BY THE ARTERIAL COUNTERPULSATOR

FIGURE 1

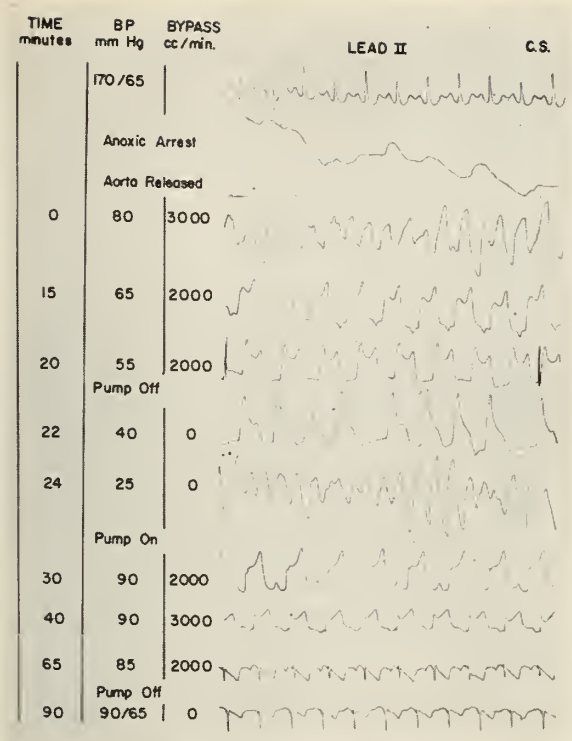



FIG. 2. *The effect of 65 minutes of venoarterial bypass required to restore myocardial function after 30 minutes of anoxic cardioplegia. Ventricular fibrillation ensued when circulatory support was prematurely interrupted at 20 minutes.*

tion of aortic insufficiency is shown in figure 2. Following resumption of coronary perfusion there ensued a period of heart failure during which the heart was unable to sustain pressure work despite reduction of flow work by left auricular sumping. The pattern of injury by electrocardiogram gradually improved on veno-arterial pump-oxygenator support. The trial without pump support resulted in immediate hypotension to 40 mm. Hg and a marked electrical deterioration. Ventricular fibrillation occurred at a pressure of 25 mm. Hg. Resumption of extracorporeal bypass with flows varying from 2000-3000 cc. per minute and mean arterial pressures maintained at 85-90 mm. Hg for an additional period of 35 minutes was followed by progressive improvement in the electrocardiogram to a more normal pattern. In all, 65 minutes of assistance was required before the heart had recovered the ability to sustain pressure work independently. In this instance adequate coronary circulation overcame the disadvantage of increased pressure work by the pump. A patient whose heart has been arrested for open surgery consistently needs some period of veno-arterial bypass support. This presumably provides the coronary circulation necessary to recover from a state of complete failure.

### Synchronized Arterial Counterpulsation

This offers the advantage of directly altering pressure work by decreasing aortic systolic pressure while maintaining coronary and systemic perfusion by increasing diastolic pressure.

Experimentally a single cannula is placed at the bifurcation of the aorta and connected to the ventricle of the Davol* pump. The ventricle is controlled by a piston actuator that can be synchronized through the electrocardiographic R wave to aspirate during systole and return during diastole. In the human a femoral cannula is used. Synchronized arterial counterpulsation at a heart rate of 70 is illustrated in figure 3. The systolic ejection periods and systolic pressures are indicated by the shaded areas. With counterpulsation, left ventricular pressure is reduced, systolic pressure is reduced, systolic ejection time is shortened, and diastolic pressure is increased.

Table 1 presents these changes in more detail. Note that while the mean aortic pressure remains unchanged, mean systolic pressure is reduced from 70 to 35 mm. Hg, a reduction of 50 per cent. Mean diastolic pressure is increased 15 mm. Hg. Diastolic peak pressures reveal an even more marked increase to levels above that of the control pressures. This is reflected in the measured coronary sinus flow of 82

*Davol Company, Providence, Rhode Island

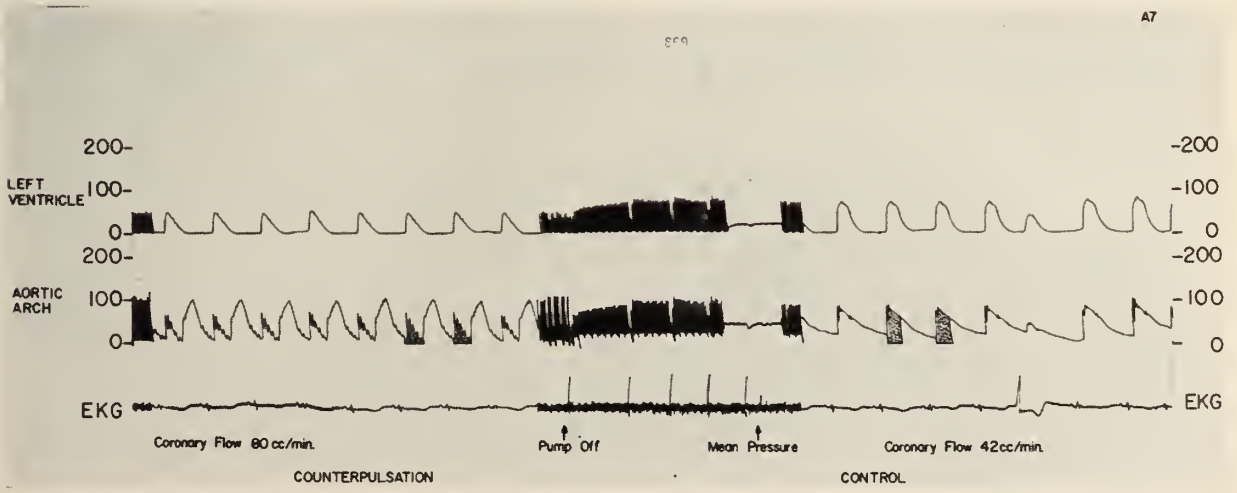



FIG. 3. *Aortic and left ventricular pressure changes during synchronized counterpulsation at a heart rate of 70/min.*

TABLE 1. *Hemodynamic changes illustrated in Figure 3.*

| | Control | Counterpulsation |
|---|---|---|
| Left Ventricular Peak Pressure | 75 | 50 |
| Mean Aortic Pressure | 50 | 50 |
| Mean Systolic Pressure–aorta | 70 | 35 |
| Mean Diastolic Pressure–aorta | 35 | 50 |
| Peak Diastolic Pressure–aorta | 60 | 100 |
| Heart Rate | 70 | 70 |
| Coronary Sinus cc min. | 42 | 80 |

cc/min. during counterpulsation versus the 42 cc/mm. control.

Similar changes at a different pressure are illustrated by synchronized counterpulsation at a rate of 100 per minute in figure 4. The reduction of systolic pressure and elevation of diastolic pressure are of lesser magnitude. Systolic mean pressure is reduced 35 mm. Hg or approximately 32 per cent of the control value. (Table 2.)

TABLE 2. *Hemodynamic changes illustrated in Figure 4.*

| | Control | Counterpulsation |
|---|---|---|
| Left Ventricular Peak Pressure | 125 | 100 |
| Mean Aortic Pressure | 100 | 90 |
| Mean Systolic Pressure–aorta | 110 | 75 |
| Mean Diastolic Pressure–aorta | 95 | 95 |
| Peak Diastolic Pressure–aorta | 105 | 130 |
| Heart Rate | 100 | 100 |

Additional physiological studies reveal that increasing heart rates impose progressive limitation on the magnitude of systolic reduction that can be accomplished though significant changes have been obtained up to rates of 190 per minute. Myocardial oxygen consumption studies demonstrate a consistent reduction of myocardial oxygen utilization. Coronary flow studies utilizing coronary sinus return show unchanged or increased coronary flow depending on the changes in peak diastolic pressures and mean arterial pressures.

In conclusion, veno-arterial bypass and synchronized arterial counterpulsation appear to have different and specific indications. *Veno-arterial bypass* supports adequate coronary and systemic flow by raising mean aortic pressure while relieving the flow work of the heart. It is particularly suited to treating severe shock and failure secondary to obstructive lesions in the heart or lesser circulation. It may have a special place when pulmonary edema is a dominant factor without an elevated left ventricular diastolic pressure. *Synchronized counterpulsation* seems well suited for myocardial assistance in acute coronary occlusion with failure because it reduces pressure work and myocardial oxygen consumption. It is hoped that these principles will extend the present treatment of heart failure.

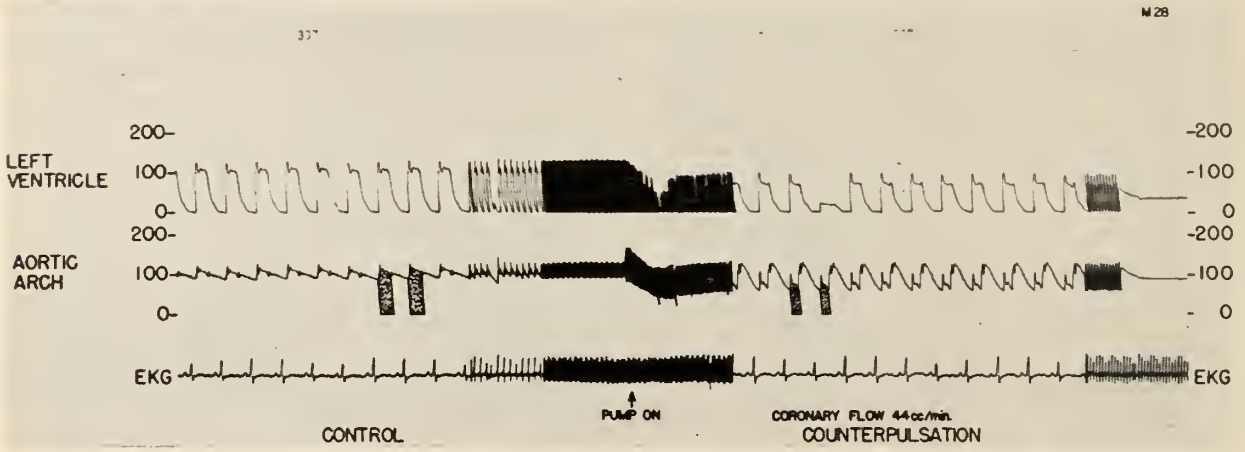



FIG. 4. *Aortic and left ventricular pressure changes during synchronized counterpulsation at a heart rate of 100/min.*

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HEAVY CIGARETTE SMOKERS experience a threefold increase in the incidence of myocardial infarction and in death from all causes as compared to nonsmokers, pipe and cigar smokers and former cigarette smokers.—Jos. T. Doyle, M.D., et. al.: *The New England Journal of Medicine*, 266:796, April 19, 1962.

Coronary Symposium

# Myocardial Revascularization

DAVID S. LEIGHNINGER, M.D.

THERE are two components of coronary heart disease. The first component concerns morbid anatomy. The second concerns physiological abnormalities that result in anginal pain and in sudden death. (Fig. 1.)

## Morbid Anatomy

Occlusion of a coronary artery results in muscle death. The amount of muscle destroyed by one or more occlusions may be so great that the heart cannot efficiently pump blood. Heart failure and death result.

Severe stenosis of coronary arteries at their origin results in reduction of blood supply to the entire myocardium. If the total inflow is reduced beyond a critical level the heart beat becomes weak and the heart stops in standstill.

## Physiological Abnormalities

Stenosis occurring distal to the common coronary artery results in decreased oxygenation of a portion of the myocardium. There is an uneven blood supply or "checkerboard" distribution of blood. Stenosis occurs in a segment of artery. Stenotic segments may be scattered anywhere throughout the coronary arterial tree. Usually many branches are uninvolved by the stenotic process and carry normal quantities of blood. An uneven distribution of blood results in a two color heart, part of which is pink and part blue. Pink muscle is well oxygenated, blue muscle is poorly oxygenated. At the boundary between the two, electric currents are generated, which produce anginal pain and may become strong enough to produce ventricular fibrillation.[1] At the autopsy table morbid anatomy can be seen. The physiological abnormalities of oxygen differentials and fibrillating currents cannot be seen. Therefore, one of the most common causes of death cannot be identified at the autopsy table.[2]

*One color heart:* If blood supply to the myocardium is uniform, the heart is a one color heart. Normally it is pink. In certain disease states it may be uniformly blue such as: generalized cyanosis due to various respiratory diseases; tetralogy of Fallot; and suffocation. If the heart is one color, whether pink or blue, it is electrically stable. The electrocardiogram shows little change. The heart becomes weak. If the heart stops it stops in standstill. Anginal pain and fibrillating electrical currents do not result from a one color heart.

*Two color heart:* A two color heart, pink and blue, results from coronary heart disease or from aberrant origin of one coronary artery. Anginal pain and sudden death due to ventricular fibrillation are common in both conditions.

One color and two color hearts have been studied in the experimental laboratory. (Fig. 2.) Electrograms taken from the surface of these hearts show the presence of a current of oxygen differential in two color hearts and its absence in one color hearts.

The current of an oxygen differential is not the same as injury current. Anoxic myocardium is not necessarily injured myocardium. To be sure, if the anoxia is severe enough and persists for a long enough time, injury can develop.

In the laboratory a dog heart was made anoxic by asphyxia. Oxygenated blood was perfused into one coronary artery, producing a two color heart. Electrograms showed the presence of a current of oxygen differential at the boundary between pink and blue. The heart went into ventricular fibrillation. Perfusion of oxygenated blood into the myocardium could not produce injury to muscle. This experiment proves the fallacy of the term "injury current" when used in place of "current of oxygen differential."

*Hearts too good to die:* Fatal fibrillating currents due to a two color heart can develop independent of structural changes in muscle or total inflow reduction. They can develop late in the course of coronary heart disease after there has been much damage to the


### *The Author*

● **Dr. Leighninger, Cleveland, is senior instructor in surgery, Western Reserve University, and University Hospitals.**


From the University Hospitals of Cleveland and the Western Reserve University School of Medicine. This work was supported by grants from the United States Public Health Service and the Cleveland Area Heart Society.

Presented before The Cleveland Area Heart Society Eleventh Annual Meeting, November 30, 1960, Cleveland, Ohio.

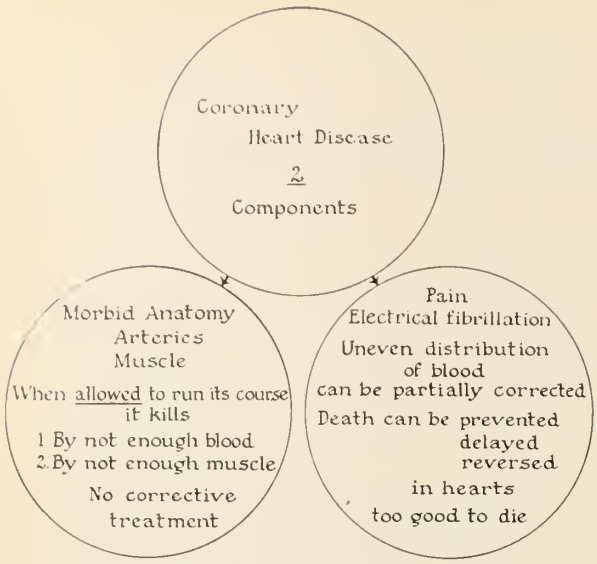



FIG. 1. *Components of Coronary Heart Disease.*

heart, or they can develop early in the course of the disease when the heart is structurally a good organ.

Adelson and Huffman[2] of the Cuyahoga County Coroner's Office have studied the hearts of 500 victims of sudden death due to coronary disease. They found there was no new disease in the arteries or myocardium in about 65 per cent of the hearts. The hearts were the same at the time of death as they were the day before, except the victim was dead. These victims were about their daily activities, in the bloom of active life. Something came and killed — and was not found at the autopsy table. The majority of these hearts were the seat of little or no structural damage. It is assumed that, had not a small death factor fibrillated these hearts, they were capable of months and years of continued function. These were hearts structurally too good to die.

On June 22, 1955, Dr. Albert Ransone suffered a fatal heart attack in the entrance of the University Hospitals of Cleveland. Dr. Elden Weckesser quickly opened the victim's chest and pumped the heart by hand. Dr. Claude S. Beck defibrillated the heart and Dr. Ransone recovered from a fatal heart attack. He was the first victim to have a fatal attack reversed.[3] The fact that he is still alive six years later is proof that his heart was too good to die. There is now a total of 10 victims of fatal attacks whose deaths were reversed at the University Hospitals. Eight of the 10 are still alive. In two victims there was so much structural damage in the heart that, in spite of defibrillation, the victims died some 12 to 48 hours later in acute heart failure. In at least four of the survivors there was damage to the myocardium as a result of coronary artery occlusion. The victims survived and are still alive in spite of the damage. Again, these hearts were too good to die. There have been reports in the literature of at least a dozen other cases of reversal of fatal heart attacks.

The results of Adelson's study would indicate that there are tens of thousands of deaths every year in the United States that could probably have been reversed if known resuscitation techniques had been applied to the victims before the brain suffered irreversible damage. Both open and closed chest methods have been successful, not only in the hospital but outside the hospital. A mechanical device constructed by H. J. Rand is capable of maintaining adequate blood pressure in both man and dogs for periods over an hour. Such a device, installed in emergency vehicles, may be applied to the victims outside the hospital to keep the brain alive until the victim reaches the hospital where either closed or open chest resuscitation techniques may be applied. Closed chest resuscitation offers hope that many victims may be successfully restored to life in the future.

## Treatment

Morbid anatomical changes due to coronary heart disease are a straightjacket to treatment. At the present time nothing can be done to reverse the changes — scar tissue cannot be made to function as muscle and the removal of stenotic areas of coronary arteries is either technically too difficult or prone to therapeutic failure due to subsequent thrombosis.

The key to surgical treatment of coronary heart

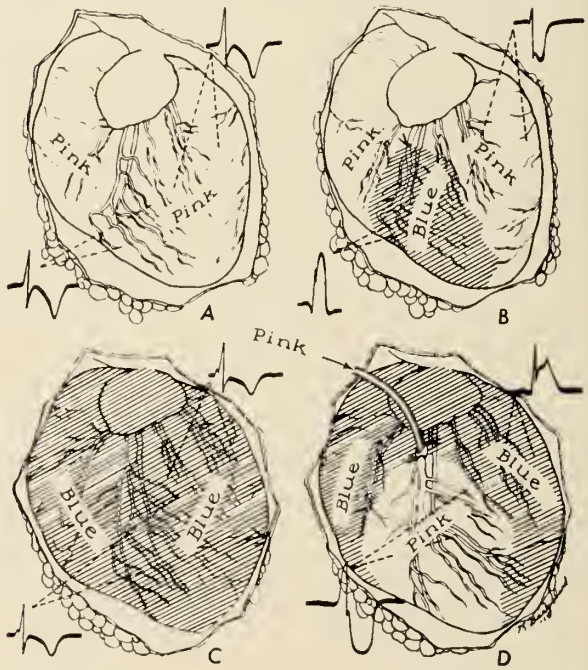



FIG. 2. *Drawings of dog hearts.* A. *Normal. Uniformly pink. Electrogram from surface normal. Electrically stable.* B. *Coronary artery ligated. Two-color heart. Electrogram shows S-T elevation over blue and depression over pink muscle. Electrically unstable. Fibrillates.* C. *One-color heart — blue. Due to asphyxia. Electrogram normal. Electrically stable. Heart becomes weak and stops in standstill.* D. *Two-color heart. Coronary artery cannulated. Perfused with pink blood. Remainder of heart blue due to asphyxia. Electrograms show current of oxygen differential as in B. Electrically unstable. Fibrillates.*

disease lies in converting a two color heart into a one color heart. A two color heart (pink and blue) can be converted to a one color (pink) heart by evenly distributing available blood through intercoronary arterial communications. The Beck I operation stimulates the heart to develop intercoronary communications. It may also add additional blood to the coronary circulation by the development of extracoronary communications in some or all of the hearts operated upon.

The vasodilating drugs also can convert a two color heart to a one color heart by opening up existing intercoronary communications.[4] Nitroglycerin, Peritrate®, and amyl nitrite add about one cubic centimeter of blood per minute to the ischemic circumflex area of the dog heart. The action is temporary. The Beck I operation adds four times this quantity of blood, and the action is permanent.

The amount of blood added by the Beck operation in dogs reduced the mortality from ligation of the anterior descending coronary artery from 70 per cent in control animals to 30 per cent in animals previously protected by operation. In the surviving protected animals the infarct size was reduced by about 60 to 70 per cent.[5]

*Results in patients:* All patients with coronary heart disease operated upon by Dr. Claude S. Beck and the author from January, 1954, until the present time received the Beck I operation or a modification. These patients comprise a study group. Hospital and late mortality have been recorded. Results in the patients have been classified as either excellent, good, fair, or unchanged. All of the patients received medical treatment for their coronary heart disease for varying periods of time prior to operation. Postoperative results were compared to their status under medical management. If a patient required no medication and was free of pain he was classified as excellent. If the patient had only an occasional pain and required only occasional medication but was significantly improved over the preoperative state he was classified as good.

Results of the study are shown in tables 1 through 3.

TABLE 1. *Clinical Results, Six Month to Eight Year Follow-Up*

| 472 Patients Living at Present Time | |
|---|---|
| Excellent | 52% |
| Good | 35% |
| Total | 87% |

TABLE 2. *Late Clinical Results, Four to Eight Year Follow-Up*

| 209 Patients Operated Jan., 1954 to Jan., 1958 | |
|---|---|
| Excellent | 53% |
| Good | 32% |
| Total | 85% |

TABLE 3. *Mortality*

| | 7,400 Patients Not Operated Upon | Patients Operated Upon Total 624 | Patients Operated Upon Good Cases 370 |
|---|---|---|---|
| Hospital | | 6.2% | 2.7% |
| 2 Years | 25% | 11.7% | 8.2% |
| 4 Years | 42% | 20.8% | 13.2% |
| 5 Years | 50% | 26.1% | 15.6% |

## Discussion

Death from coronary heart disease due to morbid anatomy resists treatment. The death factor due to physiological changes is a small death factor. This death factor, fibrillating electrical currents due to an oxygen differential in a two color heart, is mobile. Death can be brought on in a good heart by such activity as shoveling snow, hitting a golf ball, watching an exciting television program, and so-forth. If the patient had not indulged in exercise or excitement at that particular time the heart probably would have continued to beat. The oxygen differential would not have become strong enough to fibrillate the heart. A second aspect of the mobility of a small death factor is its reversibility as shown by the cases of fatal heart attack in which death was successfully reversed. A third aspect of mobility is the fact that it can be prevented by treatment.

Table 3 compares late mortality in the patients protected by operation with a large group of patients not treated by operation. The death rate in the operated group was one-half that of the non-operated group. This indicates that production of a one color heart by surgical stimulation of intercoronary communications significantly reduces death from fibrillating currents. This evidence supports the concept that the key to treatment of coronary heart disease is production of a one color heart, i. e., one with a uniform distribution of blood.

The clinical results in patients indicates that production of a one color heart relieves anginal pain. The results in patients operated upon many years ago indicates that the benefit of operation continues over a period of years. It also indicates that benefit is not a placebo effect. It is recognized that a placebo effect plays some role in benefit during the first year. It should be noted that patients are not evaluated until at least six months following operation.

It is the author's opinion that results in patients indicate the Beck I operation is the best available treatment for coronary heart disease.

## Summary

1. Morbid anatomical changes in coronary heart disease resists treatment.

2. Oxygen differentials resulting from an uneven distribution of coronary blood produce electrical currents responsible for anginal pain and sudden death.

3. The death factor in "hearts too good to die" has mobility. It can be prevented by operation, can

be brought on in a structurally good heart, and can be reversed in many patients.

4. In 624 patients operated upon over an eight year period the hospital mortality was 6.2 per cent, the late mortality was one-half the expected mortality, excellent or good clinical results were obtained in 87 per cent and the clinical improvement prevails after four to eight years.

5. The Beck I operation constitutes the best available therapy for coronary heart disease.

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RHEUMATIC FEVER MANAGEMENT. — The author outlines his current views on the management of rheumatic fever. He is sure of the value of the regimens he recommends for prevention, but he is far from sure as to the value of the measures he suggests for the treatment of the patient with carditis. Corticosteroids and salicylates, although perhaps occasionally life-saving in acute rheumatic fever with pericarditis and myocarditis accompanied by high fever and toxicity, probably do not affect the ultimate damage to the values. He uses them in the hope that they may be of some help and with the reasonable assurance that the recommended doses will not do harm.

1. Any person with an upper respiratory infection, whether or not he is a rheumatic subject, should be given a single intramuscular injection of 600,000 to 1,200,000 units of benzathine penicillin G or be given oral penicillin, 250,000 units four times daily for ten days.

2. Continuous prophylaxis should be given to any child who has had proven rheumatic fever and any adult who has inactive rheumatic heart disease or who has had an attack of rheumatic fever within five years. Prophylactic therapy should consist of an intramuscular injection of 1,200,000 units of benzathine penicillin G every month or sulfadiazine in daily oral doses of 0.5 Gm. for children under 60 lbs. and 1 Gm. for heavier persons.

3. Intensive penicillin treatment should be given to any patient with active rheumatic fever, whether it is an acute attack or "smoldering" carditis. Because there is some evidence that larger doses are preferable, the author suggests that the injections of benzathine penicillin G be given every two weeks instead of monthly for the first three doses (or for a longer time if corticosteroids are still being given).

4. If carditis is present and treatment can be started within three weeks of onset, the author gives prednisone in oral doses of 10 to 15 mg. four times daily for 10 days. He then reduces the total daily dose at the rate of 2.5 mg. daily. He gives salicylates in addition and continues them after corticosteroid has been withdrawn, for as long as there is evidence of continuing disease activity.

5. He insists on complete bed rest during the phase of acute signs and symptoms, but thereafter allows the patient to sit quietly for very gradually increasing periods each day.

6. Continuous prophylaxis begun during the acute illness is continued as described in paragraph 2. — ABSTRACT: Currier McEwen, New York, N. Y.: *Arthritis Rheum.*, 4:310-313 (June) 1961.

# Internal Mammary Artery Implantation

## Survey of Fifteen Years of Experimental Study and Ten Years' Experience with Human Cases

ARTHUR VINEBERG, M. D. C. M.

THE TREATMENT of coronary artery insufficiency by surgery or by medical measures has been, and still is, a most controversial subject. The clinical course of the disease is so entirely unpredictable that evaluation of any treatment has been difficult. It has been stated that "anything will cure anginal pain" — a new medicine, a change of job, a small operation, or nothing more than the lapse of time. The disease appears to run an irregular course which may vary from complete disappearance of anginal pain to sudden, unexpected death.

At present, in spite of the optimistic reports about all forms of treatment, there continues to be a mounting morbidity and mortality in both Canada and the United States from coronary artery heart disease.

Pathologists agree that, whatever the cause, obstructive disease of the major coronary arteries in their epicardial courses is responsible for coronary artery insufficiency and for its many sequelae. Further, there are no known chemical enzymes or drugs which can dissolve these atherosclerotic deposits any more than there are chemicals which can dissolve gallstones or renal calculi. If these facts are accepted, then obstructive disease of the coronary arteries, like obstructive disease in other body systems, requires surgical treatment for its relief.

The type of operation performed will vary according to the underlying pathology and, as elsewhere, the surgeon may have the choice of four or five procedures to accomplish his objective. In our clinic we have favored bypass operations which introduce extracoronary oxygenated blood into the ischemic left ventricle by circumventing narrowed or occluded coronary arteries. Evaluation of operative procedures designed to relieve myocardial ischemia is extremely difficult. However, if surgery for the treatment of coronary artery disease is to be performed, then it must be placed upon a firm footing.

During the past 10 years our group has attempted to establish certain laboratory and clinical criteria which may be used in the selection of patients for surgical revascularization and the evaluation of these patients following surgical revascularization procedures.

Presented before The Cleveland Area Heart Society Eleventh Annual Meeting, November 30, 1960, Cleveland, Ohio.


### *The Author*

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In the laboratory, before a revascularization procedure is given credit for being of value, at least two facts must be clearly established: (1) That there be demonstrated the development of extracoronary

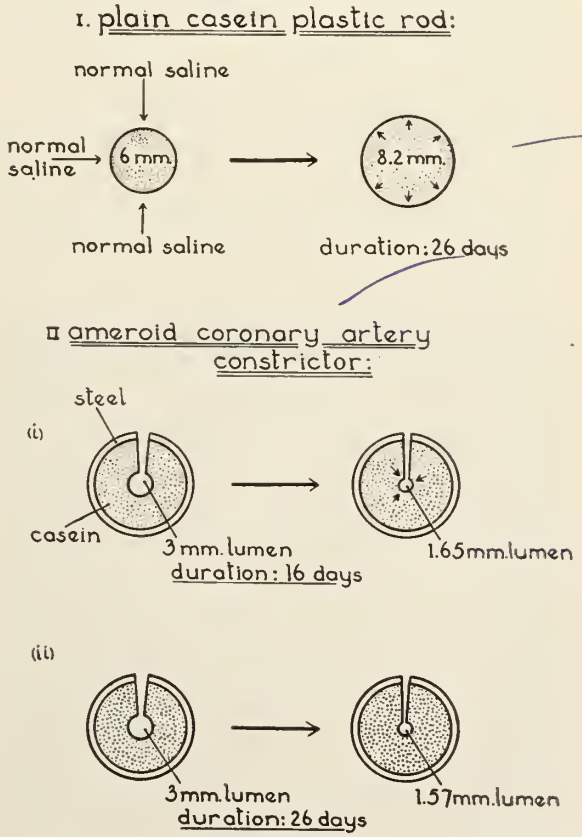



FIG. 1. *Casein bar with central lumen and slot housed in steel jacket which prevents eccentric expansion as ameroid swells after water absorption.*

vascular channels capable of carrying large quantities of oxygenated blood to the ischemic myocardium, and (2) Survival Test — That an operative procedure must be capable of preventing the death of an animal when two or more major coronary arteries are occluded.[1,2,3,4]

Laboratory survival tests have been criticized because of the great variation of results. On this account we have developed the ameroid coronary artery constriction test (Figs. 1 and 2) which slowly oc-

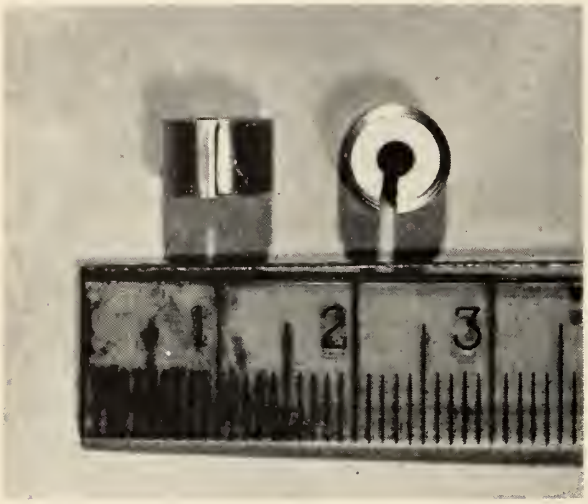


FIG. 2. *Complete ameroids with steel sleeves ready for application to anterior descending and circumflex coronary arteries.*

cludes the origins of the anterior descending and circumflex coronary arteries (Figs. 3 and 4) and results in the death of 85 to 100 per cent of all control animals within an average period of 20 to 28 days. In numerous series, totalling well over 300 control animals, the only animals to survive this test were



FIG. 3. *Shows coronary artery ameroid constrictors in situ around the origins of the anterior descending and circumflex branches of the left coronary artery.*



A

B

FIG. 4. *Photomicrograph sections taken through site of ameroid placement on coronary arteries.* (A) *Microscopic section through the anterior descending branch within the ameroid. Note the obstruction of the lumen and thickened media with chronic inflammatory cells. This was considered to be 85 per cent occluded.* (B) *Photomicrograph of section taken through the circumflex artery at the site of ameroid constriction, showing 90 per cent occlusion of the lumen.*

those in whom there was a large right to left coronary anastomosis.

Many different types of revascularization operations have been tested, and we have found that the most effective protection against coronary ameroid constriction death is afforded by two operations, namely,

1. The internal mammary artery implantation operation.
2. The Ivalon sponge operation.

### The Internal Mammary Artery Implantation Operation

Fifteen years of experience has shown clearly that an internal mammary artery implanted into the left ventricular wall forms many anastomoses with the ventricular arteriolar system (Figs. 5 and 6).[5,6,7,8,9,10,11,12,13,14,15,16,17,18] The internal mammary artery is usually of large size, being as large or larger than a major coronary artery. It has been shown that the internal mammary artery remains widely patent in 80 per cent of arteries implanted into ischemic animal hearts, and in 70 per cent of ischemic human hearts (Figs. 7, A, B, C). In the human heart, implanted internal mammary arteries have been found lying in the left ventricular myocardium completely patent four years postoperative. Injection studies have outlined extensive mammary-coronary anastomoses in these hearts. In one patient who died of a ruptured right ventricular aneurysm, the only artery which was open in the heart was the internal mammary artery which had been placed there three and a half years previously.



FIG. 5. *Roentgenogram of coronary arteriolar system of animal heart made by injecting Schlesinger mass into the left internal mammary artery only 12 months after its implantation into the left ventricle. This animal survived ameroid coronary artery constriction.*

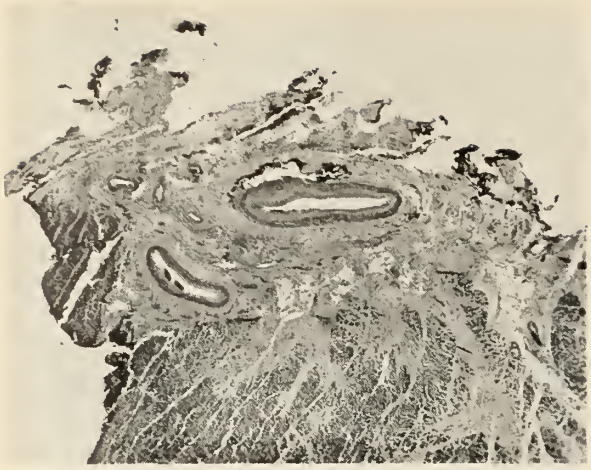


FIG. 6. *Digestion cast of animal heart and implanted internal mammary artery seven months after implantation. Note large arterial branches arising from the implanted artery.*

Blood flow rates up to 55 cc. per minute have been measured going down the implanted vessel into the animal's heart, and 60 per cent has been recovered from the coronary sinus. In addition, recently by cine-angiograph it has been shown that radiopaque dye injected into the left subclavian artery flows down the implanted internal mammary artery to fill the coronary arteries of the left ventricle.

From our studies it would appear that an implanted internal mammary artery supplies sufficient blood to the left ventricle to prevent ameroid coronary artery constriction death in the animal, and to maintain the health of the left ventricle in man when both major left coronary arteries have been occluded by disease. However, not more than 70 per cent of transplanted internal mammary arteries remain open in man and form effective mammary-coronary anastomoses. Further, although the artery is large enough to supply a normal-sized left ventricle when both major left coronary arteries are occluded, it is not large enough to supply the whole heart or the large muscle mass present in cases of left ventricular hypertrophy. Because of this fact, some years ago we commenced searching for other revascularization procedures which might effectively supplement the internal mammary artery implantation operation, and tested them according to our criteria of value.

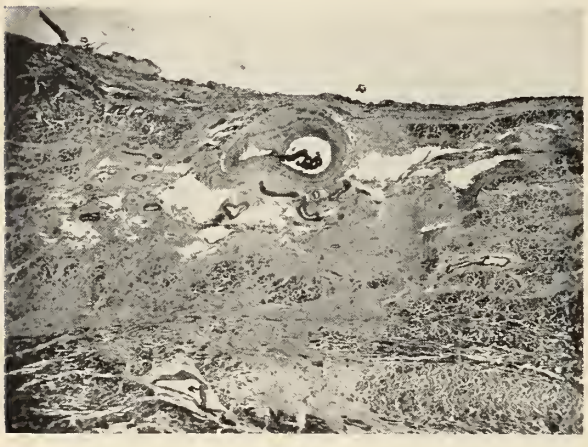
The following operations were tested and found to



A



B



C

FIG. 7. *Photomicrographs of serial sections taken through implanted human internal mammary artery 18 months after implantation. Patient became angina free and died from cancer of the pancreas. Specimen flattened due to deep freeze.* (A) *Flattened internal mammary artery at entrance to tunnel widely open showing minimal intimal proliferation and containing India ink injected through the circumflex artery.* (B) *First one third of tunnel showing branching within tunnel; no intimal proliferation.* (C) *End of tunnel; artery reconstituted, open, and still branching.*

be of no value, namely, pericardial poudrage by talc, asbestos, coral powder, or different types of marine sponge dust; omental or jejunal grafts, or lung grafts including ligation of the pulmonary artery at the time of grafting. Likewise, iliac, femoral or nylon tube grafts anastomosed to the thoracic aorta at one end, with implantation of the other end into the left ventricular myocardium, have failed to remain open.

The attempted creation of artificial thebesian canals by tapping the left ventricle, using free arterial grafts or plastic tubes, has also been unsuccessful. Pericardial fat pad graft supplements appeared to be of value[12,19] but frequently in man these are very small and fibrotic.

The operation which, in addition to the internal mammary artery implant procedure, has proven extremely effective in preventing ameroid coronary artery constriction death, has been the Ivalon sponge operation.[20,21,22]

### The Ivalon Sponge Operation

This operation protects 85 per cent of animals against ameroid constriction death. It is not clearly known how this operation works. It has however been shown that numerous mediastinal vessels (Fig. 8) pass through the interstices of the Ivalon sponge (Fig. 9) and penetrate the surface of the left ventricle to join with the vascular spaces of the ventricu-



FIG. 8. *Roentgenogram made by injecting left subclavian artery and thoracic aorta with Schlesinger mass in animal in situ in Ivalon sponge treated animal which survived ameroid coronary artery constriction. Note numerous vessels reaching sponge and heart from branches of the internal mammary artery and from the aorta.*

lar myocardium. Following the application of the Ivalon sponge to the surface of the left ventricle it seems that mediastinal vessels are guided to ventricular channels through the interstices of the sponge. Further, the operation appears to stimulate the formation of arterio-luminal and luminal sinusoidal vessels (Figs. 10 and 11).

Injection studies of the left ventricular lumen with Schlesinger mass in control animals, and in Ivalon sponge treated animals have been performed, and x-ray studies of these animals have shown filling of coronary arteries through the ventricular wall in the Ivalon sponge treated animals, but not in the control animals (Fig. 12). Histological studies of hearts injected with Schlesinger mass only through the left ventricular lumen have shown the Schlesinger mass distributed throughout the myocardium via large openings which penetrate the wall of the left ventricle for at least two thirds of its thickness. The Schlesinger mass thus injected has been found in myocardial sinusoids and other myocardial vascular spaces (Fig. 13, A and B).

The development of these spaces and vessels following the Ivalon sponge operation has suggested that in addition to supplying blood to the myocardium via numerous mediastinal vessels, it is possible that the ventricle syphons oxygenated blood from its own lumen through these spaces to nourish the ischemic myocardium (Fig. 14). It should be pointed out that the possibility of endocardial nutrition through these spaces is purely theoretical and has not as yet been proven. However, in addition to the experimental evidence, there is some clinical evidence to support this point of view. In our human series, where there has been severe left ventricular failure, the patients after anesthesia usually require a continuous Neo-Synephrine® drip and a 30° Trendelenberg position to maintain blood pressure above 80 mm. of mercury.

We have observed two interesting facts in these patients: the first appears to be related to the removal of the epicardium from the left ventricle. As the epicardium is removed, the patient's blood pressure



FIG. 9. *Photomicrograph of a section of the heart of Animal No. 838 showing sponge spaces lined by endothelium and containing red blood cells. This study was made 176 days after operation.*



FIG. 10. *Roentgenogram of Ivalon sponge in heart of animal No. 435 in which the anterior descending and circumflex arteries were injected with Bellman-Frank mass distal to ameroid constriction and right coronary artery. Numerous vessels are shown leaving surface of coronary arteries running towards the ventricular lumen. Note the number and their tendency to palisade and form numerous intercoronary anastomoses.*



FIG. 11. *Low power histological section of the heart of Animal No. 685 showing numerous communications between surface of the left ventricle in the region of the sponge and the left ventricular lumen. The sponge contains Schlesinger mass injected through the anterior descending coronary artery distal to the point of ameroid constriction.*

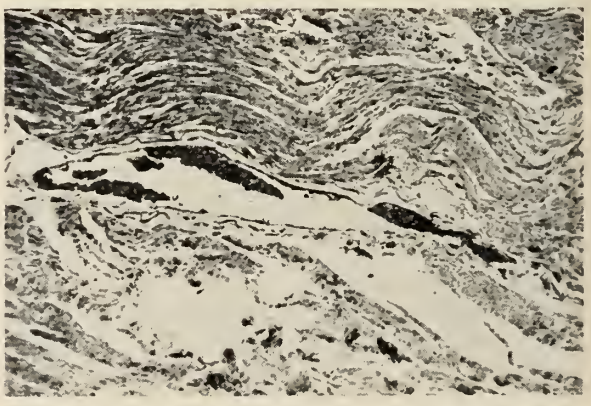


FIG. 12. *Roentgenogram of Schlesinger mass injection into left ventricular lumen — coronary arteries severed at their origins. Aorta occluded at its origin. Ivalon sponge animal that survived ameroid coronary artery constriction. Note filling of ventricular vascular spaces.*

improves. In most cases, before the Ivalon sponge sheets are applied to the heart, the patient requires no further Neo-Synephrine and can maintain an adequate blood pressure in the horizontal position. The second fact relates to the closure of the pericardium in this type of heart. The pericardium is usually difficult to close, and after it is closed there is a considerable drop in blood pressure which is immediately corrected by re-opening the suture line of the pericaridum. I have found it necessary to make a counter incision posteriorly in the pericardium, vertical



A



B

FIG. 13. *Photomicrograph of ventricular wall of Ivalon sponge animal after left ventricular cavity Schlesinger mass injection.* (A) *Large vascular space communicating with cavity; left ventricle penetrates two-thirds thickness of ventricular wall and contains Schlesinger mass.* (B) *Filling of myocardial sinusoid with Schlesinger mass after left ventricular cavity injection.*

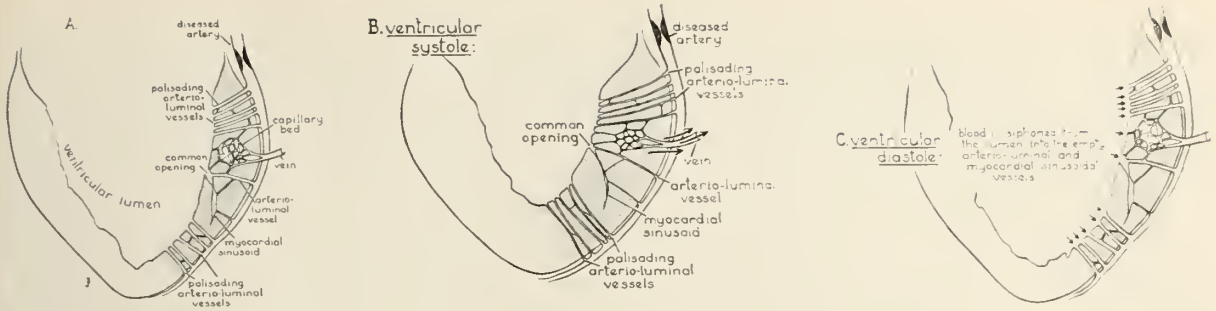



FIG. 14. *Schematic drawing showing arterial and sinusoidal luminal vessels of left ventricular wall which are in communication with the ventricular cavity. These spaces are emptied through the capillaries into the veins during systole. It is postulated that during diastole they are filled by syphoning blood into the ventricular wall from the ventricular cavity.*

in direction from base to apex, into which is sewn a sheet of Ivalon sponge 1 to 1½ inches wide. This is the first time that I have observed a heart dilate and at the same time improve in function. The increase in heart size and improvement in heart function fits in very well with the experimental evidence that has been gathered to suggest that the myocardium, after removal of its epicardium, is so-loosened as to permit the syphoning of blood from its ventricular lumen into itself. At the present time we are carrying on an active investigative experimental and clinical study on the effect of the removal of the epicardium on endocardial nutrition.

## Clinical Criteria

The pre- and post-operative evaluation of patients suffering from coronary artery heart disease has presented many problems, some of which are as follows:

*Proof of Anginal Pain as a Cause of Disability:* The evaluation of subjective symptoms has always been difficult. Pain, as felt by the patient, cannot be measured, and for this reason in dealing with patients said to be suffering from anginal pain, concrete objective evidence of disability must be obtained before consideration is given to revascularization surgery.

*Work Record:* Perhaps the most important single bit of evidence pertains to the patient's work record. In our series of 110 studied cases this has been of particular importance since in this entire group there were only five patients from the executive class. The others were workers, mostly laborers, artisans, etc., who had to and wanted to work. Those patients suffering from genuine angina caused by coronary artery heart disease showed a diminishing work pattern. Many continued to work, using nitroglycerine, but usually at an easier and, many times, a less remunerative job.

*Psychiatric Examination:* In order to assess the reliability of a patient's history, every patient has had a routine examination by a psychiatrist who attempts to estimate how much of the patient's pain is caused by an organic lesion and how much is due to a psychiatric cause. Occasionally there has been divergence of opinion between the psychiatrist and the cardiologist, particularly when the electrocardiogram has failed to show the changes which usually would be associated with the severity of the patient's complaints. This type of problem and others associated with the evaluation of a patient with coronary artery insufficiency has been greatly aided by the coronary arteriogram.

*Coronary Arteriogram:* During the past year coronary arteriographs have been performed upon all patients being considered for revascularization surgery, unless the presence of left ventricular failure has contraindicated such an examination. Here we have applied the facts of experimental ameroid coronary artery constriction which has indicated that in the animal, at least, there is a point of critical coronary artery narrowing. This point is reached when the lumina of two major coronary arteries have become narrowed 50 per cent or more of their combined average lumina (Fig. 15). When human coronary arteriograms show marked narrowing of two major coronary arteries, it is my belief that the patient has reached a critical point of coronary artery narrowing and is in danger of further myocardial infarction, and possibly of sudden death. In such cases revascularization surgery is most definitely indicated.

*Heart Failure with Anginal Pain:* With the devel-

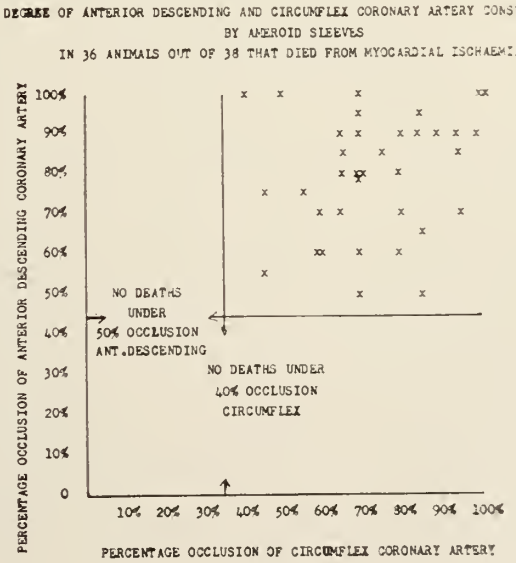



FIG. 15. *Graph showing point of critical coronary artery narrowing.*

opment of the Ivalon sponge operation and its success in the animal in preventing ameroid coronary artery constriction death, it was suggested by MacMillan that the Ivalon sponge operation be applied to those cases in which internal mammary artery implantation was contraindicated, namely, to those patients over 60 years, and to those patients with left ventricular enlargement and heart failure.

MacMillan pointed out that chronic left ventricular failure resulting from prolonged myocardial ischemia and repeated infarctions rarely recovers spontaneously. Such cases he suggested would provide excellent objective evidence of the value of a revascularization operation, particularly if such patients became pain free and, more important, heart failure free.

Thus, in evaluating a revascularization procedure, we feel that if a patient's pain disappears, or is less, and this is accompanied by a markedly improved work record, then it has to be assumed that the patient has been helped by surgery. Certainly the objective evidence of disappearance of left ventricular failure and decrease in left ventricular size, if it occurs, cannot be negated or explained away on the basis of the variability of coronary artery heart disease.

## Results

The analysis of the results of three different types of operative procedures in the treatment of coronary artery heart disease have been based upon the previously mentioned criteria and are indeed most interesting.

### The Operation of Internal Mammary Artery Implantation Alone. (Table 3)

Hill has studied our first 36 consecutive patients who received internal mammary artery implantation. Of these, there were 31 who survived operation and who have been followed five to nine years. He points out that of the five operative deaths, four would not be accepted today for any form of revascularization surgery, due to instability of their disease, or because of the presence of angina at rest without exciting cause.

The work record reveals that, prior to operation, 61 per cent of the patients had been unable to work at any type of job for five months or more, and that 39 per cent were working at easier jobs. After operation 74 per cent returned to work at their previous occupations. Men have been returned to work as farmers, machinists, applegrowers, aircraft workers, cattle buyers, oil prospectors, laborers, carpenters, woodworkers, builders, etc. Women have been returned to industry, to their homes and, in one instance, as a night charwoman cleaning a railroad station.

It is interesting to note that there was symptomatic improvement in 67.70 per cent of these cases, and that this persisted throughout the five to nine year follow-up-period in 48.4 per cent.

Hill pointed out that the first year after operation only 7 per cent of the group were completely pain free but that by the third year 38 per cent had become pain free, which he suggests is a good argument against the frequently stated psychological factors accounting for improvement following coronary artery revascularization surgery.

### The Ivalon Sponge Operation. (Table 1)

The second operation pertains to the Ivalon Sponge Operation for left ventricular enlargement and failure with anginal pain. In this group there were 22 patients, with two operative deaths. There were 20

Table 3

**SURGICAL TREATMENT OF CORONARY ARTERY HEART DISEASE**

| | SYMPTOMATIC IMPROVEMENT | | | | WORK RECORD* | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | PREOPERATIVE | | POSTOPERATIVE | |
| | TOTAL NO. CASES | PERSISTENT | TEMPORARY | UNIMPROVED* | NOT WORKING | WORKING | NOT WORKING | WORKING |
| INTERNAL MAMMARY ARTERY IMPLANTATION ALONE - 5 TO 9 YEARS STUDY IN 31 OF 36 CONSECUTIVE CASES SURVIVING OPERATION | 31 | 15 (48.4%) | 6 (19.3%) | 10 (33.3%) | 19 | 12 (39%) | 8 | 23 (74%) |
| | | SYMPTOMATIC IMPROVEMENT 21 (67.7%) | | | | | | |
| IVALON SPONGE OPEPATION FOR LEFT VENTRICULAR ENLARGEMENT AND FAILURE WITH ANGINAL PAIN - 4 TO 25 MONTHS STUDY OF 17 OF 19 CONSECUTIVE CASES THAT SURVIVED OPERATION | 17 | 14 (82.3%) | 1 (5.9%) | 2 (11.8%) | 12 | 5 (29.4%) | 4 | 13 (76.4%) |
| | | SYMPTOMATIC IMPROVEMENT 15 (88.2%) | | | | | | |
| INTERNAL MAMMARY ARTERY IMPLANTATION WITH IVALON SPONGE - 8 TO 28 MONTHS STUDY OF 11 CONSECUTIVE CASES WITHOUT OPERATIVE OR LATE MORTALITY | 10 | 7 (70%) | 2 (20%) | 1 (10%) | 7 | 4 (40%) | 0 | 10 (100%) |
| | | SYMPTOMATIC IMPROVEMENT 9 (90%) | | | | | | |

* OFF WORK 5 MONTHS OR MORE

TABLE 1

## IVALON SPONGE OPERATION FOR THE TREATMENT OF CORONARY ARTERY INSUFFICIENCY WITH LEFT VENTRICULAR FAILURE

| NO. CASES | 60 YRS. OF AGE OR OVER | NO. OF CASES WITH PREOPERATIVE INFARCTION | | LEFT VENTRICULAR ENLARGEMENT AND FAILURE | | PULMONARY AND PERIPHERAL OEDEMA | PAIN | WORKING |
|---|---|---|---|---|---|---|---|---|
| | | ONE | TWO OR MORE | SEVERE | MODERATE | | | |
| 22 | 6 | 7 | 13 (20) | 9 | 5 (14) | 8 | 22 | 5 |

### RESULTS OF OPERATION

| NO. CASES | MORTALITY | | TIME SINCE OPERATION (MONTHS) | RETURN OF LEFT VENTRICULAR FAILURE | PULMONARY AND PERIPHERAL OEDEMA | DECREASE IN LEFT VENTRICULAR SIZE | PAIN | | | RETURNED TO WORK |
|---|---|---|---|---|---|---|---|---|---|---|
| | OPERATIVE | LATE | | | | | NONE | LESS | SAME | |
| 19* | 2 | 3* | 4-25 | 1 | 0 | 3 | 11 | 4 | 2 | 14 |
| | | | | | | | | | | STILL WORKING 11 |

*3 CASES 6 WEEKS TO 2½ MONTHS POSTOPERATIVE

1. CASE J.B. DIED 22 MONTHS POSTOPERATIVE IN A FIGHT. HAD BEEN WORKING WITH SLIGHT PAIN.
2. CASE J.K. DIED 16 MONTHS POSTOPERATIVE, SUDDENLY. HAD BEEN WORKING.
3. CASE M. AMB. DIED 3 MONTHS POSTOPERATIVE OF INFLUENZA, NO RECURRENCE OF HEART FAILURE.

patients who had had one or more previous infarctions, and 14 patients who suffered from left ventricular enlargement and failure at the time of operation. Eight of the patients on admission had pulmonary and peripheral edema. Twenty-two had severe anginal pain, and only five were working. Three of the cases are recent, under eight weeks, so that the study pertains to 17 of 19 consecutive cases that survived operation, followed from 4 to 25 months. In this group there were three late deaths — one patient was killed in a fight 22 months after his operation; another died suddenly 16 months postoperative (both of these had been working); the third patient died three months after operation, of influenza, with no evidence of recurrence of heart failure.

There was symptomatic improvement in the group of 88.2 per cent, with persistent improvement in 82.3 per cent, and recurrence of left ventricular failure

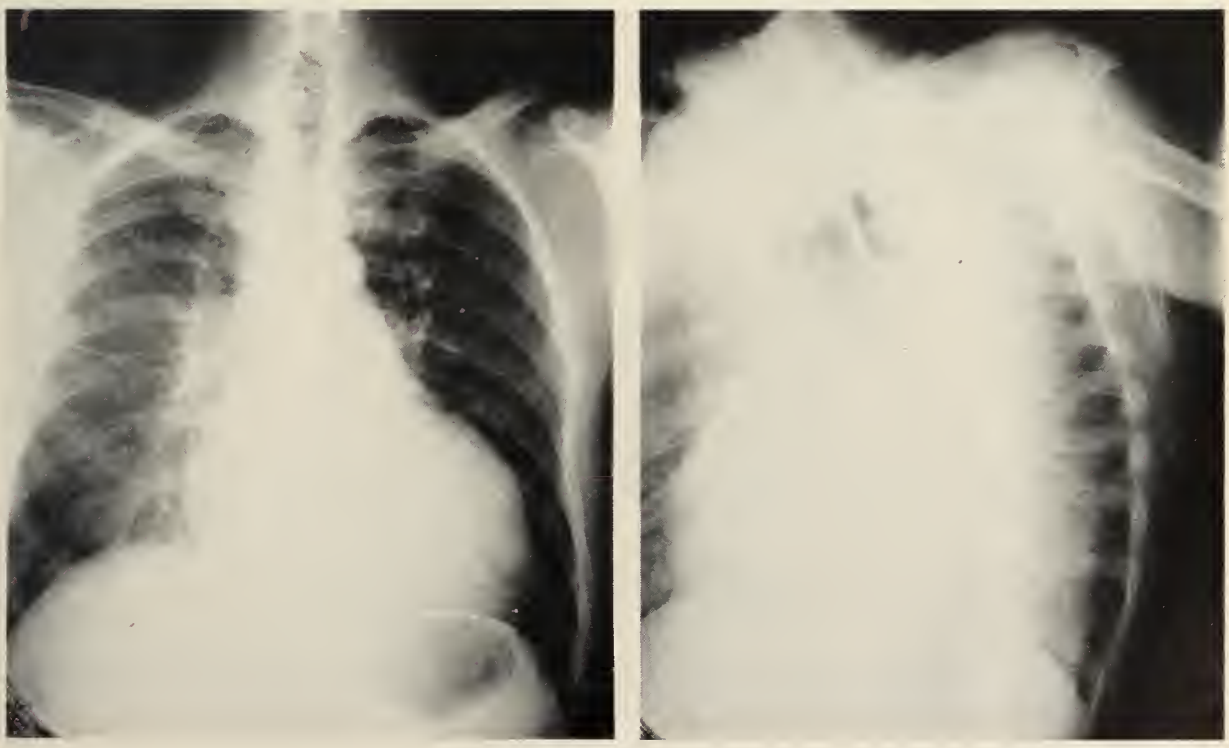


FIG. 16. *X-Ray of 60 year old physician; four myocardial infarctions. Hospitalized six months due to repeated attacks of pulmonary edema. Roentgenogram shows size of left ventricle at time of operation in May, 1960.*

and pulmonary or peripheral edema in only one patient, who is slowly getting better (Fig. 16). There has been a decrease in left ventricular size in three cases (Fig. 17). Concerning the work record, 29.4 per cent had been working before surgery, and 76 per cent are working after surgery.

### Third Type of Operation — Internal Mammary Artery Implantation with Ivalon Sponge Operation. (Table 2)

In this group there were 11 patients, nine of whom had had previous infarctions and all of whom had anginal pain. One patient is postoperative under six months, and 10 patients have been followed 8 to 22 months. There has been symptomatic improvement in 90 per cent, and this has persisted in 70 per cent. The work record of this group shows that 40 per cent were working prior to surgery, and 100 per cent are now working after surgery.

Table 2

**INTERNAL MAMMARY ARTERY IMPLANTATION PLUS IVALON SPONGE OPERATION**

| NO. CASES | AVERAGE AGE (45.5 YEARS) | NO. CASES WITH PREOPERATIVE INFARCTION | PAIN | WORKING |
|---|---|---|---|---|
| 11 | 34 TO 60 YEARS | 9 | 11 | 4 |

**RESULTS OF OPERATION**

| NO. CASES | MORTALITY | | TIME SINCE OPERATION (MONTHS) | PAIN | | | RETURNED TO WORK |
|---|---|---|---|---|---|---|---|
| | OPERATIVE | LATE | | NONE | LESS | SAME | |
| 10 | 0 | 0 | 8-22 | 4 | 5 | 1 | 10 |

† UNDER 6 MONTHS POSTOPERATIVE

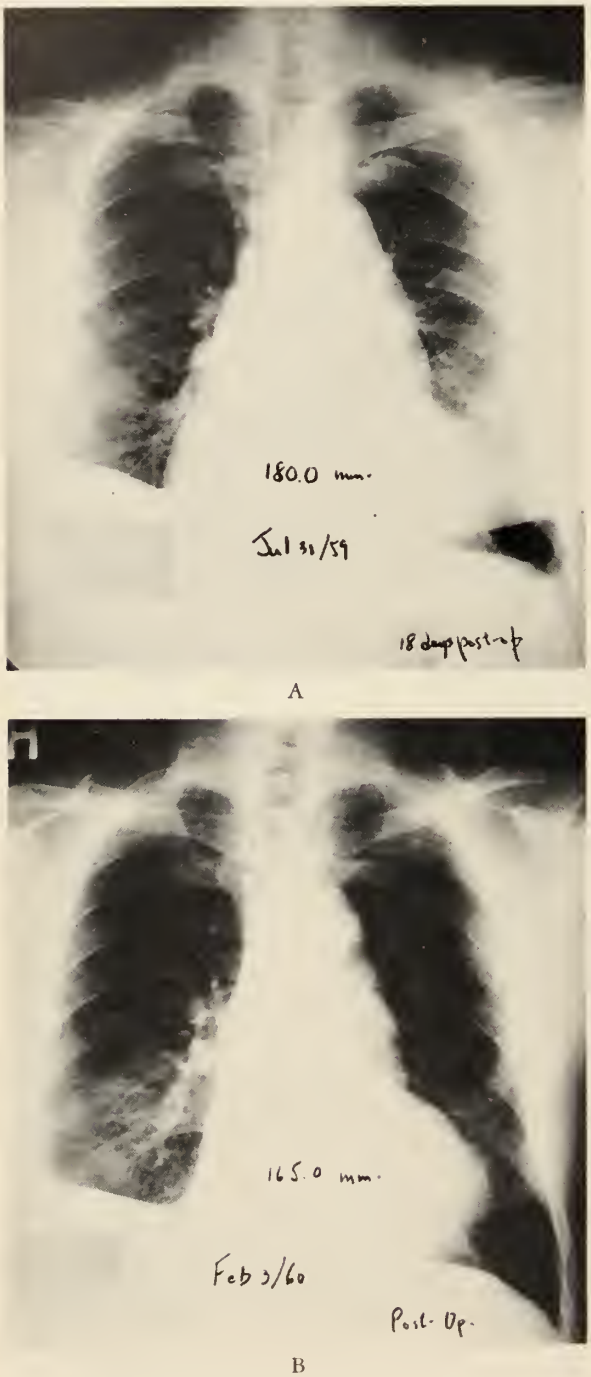



Fig. 17. *Roentgenogram of 63 year old man with left ventricular failure. Successful sponge operation July 1959. Note reduction in size of heart.*

### Pathological Studies

We have obtained objective evidence of the presence of extracoronary vascular channels in internal mammary artery implant patients and in the Ivalon sponge patients who have died for one reason or another postoperatively.

MacMillan has shown in a series of 15 human internal mammary artery cases which have been studied



Fig. 18. *Roentgenogram of human heart injected through the internal mammary artery implanted 3½ years previously. Note patency of the implant and the distribution of its branches throughout the heart.*

up to four years after implantation, that 10 of the arteries were open for their entire length including the portions lying within the myocardium. Four of these had been implanted from one and one-half to four years (Fig. 18).

In addition to this, there were many anastomotic

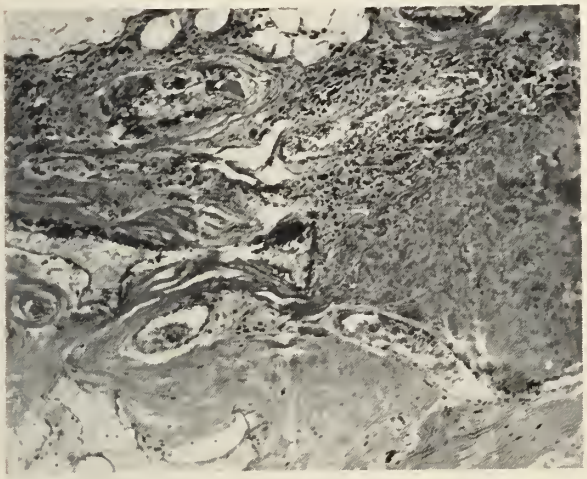


FIG. 19. *Photomicrograph of blood vessels in the sponge of a patient operated upon 22 months previously, who improved, returned to work, and was killed in a fight.*

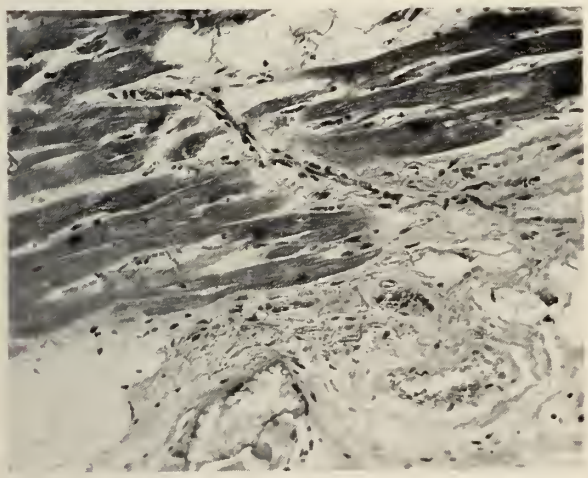


FIG. 20. *Photomicrograph of same patient as in Fig. 19, showing a blood vessel leaving the sponge area and penetrating the myocardium.*

channels between the implanted internal mammary artery and the arterioles of the left ventricle.

Concerning the Ivalon sponge operation, it has been possible to study the sponge from the heart of a patient who died 22 months after operation, and in whom there had been marked improvement. The sponge was found to be soft, starting to disintegrate, and to contain many large spaces which were filled with red blood cells and lined by endothelium, (Fig. 19). Serial sections in two planes traced blood vessels from the pericardium into the sponge, and from the sponge into the myocardium (Fig. 20) indicating that extracoronary blood vessels had reached the myocardium from the pericardium in man, just as they had in the animal.

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PICKWICKIAN SYNDROME in the case of a 40 year old man was studied at autopsy. The pertinent observation was marked infiltration of the respiratory musculature by fat, which was considered of sufficient magnitude to interfere with normal respiratory mechanism and to contribute to the characteristic alveolar hypoventilation of this disorder.—Edward J. Fadell, M.D., et al.: *The New England Journal of Medicine*, 266:861, April 26, 1962.

# Perforation of Normal Colon By Barium Enema

## Report of a Case with Uncomplicated Survival

LEONARD B. GREENTREE, M. D., and WESLEY FURSTE, M. D.

VERY FEW case reports of perforation of normal rectum and colon by barium enemas are to be found in the medical literature. While these cases are rare, it is impossible to guess at the actual number, because they form a group of cases that are only reluctantly spoken of and rarely reported. Fargol[1] in 1956 described a perforation of a normal rectum with a fatal outcome and discussed the legal implications of the case. He was unable to find in the world literature another case report describing perforation of normal rectum or colon by a barium enema.

In Fargol's case, the patient was treated immediately for shock, and a laparotomy was done about one hour after the normal rectum had been perforated by a barium enema. The barium enema was seen to cover the entire surface of abdominal cavity, and hemorrhagic areas were noted on the bowel. The perforation of the rectum was missed at the time of surgery. A descending colostomy was performed, and a drain was inserted in the rectum up to the level of the pouch of Douglas. The patient died 35 hours after surgery. Autopsy revealed generalized peritonitis with a "pea-sized" perforation of the rectum about 2 to 3 centimeters above the anus.

In 1957, Hartman and Hills[2] reported two infants suffering rupture of a normal colon by a barium enema. One was four days old. Surgery was done two hours after perforation of the bowel by a barium enema. The rent in the bowel was closed, and a transverse colostomy was done. The infant died 37 hours after surgery, and autopsy revealed fibrinopurulent peritonitis.

The other was eight months old. Surgery was done 11 hours after rupture of the normal bowel by a barium enema. In this case, the rent in the bowel was closed, and a sigmoid loop colostomy was done. The child was in a critical condition for several days. The colostomy was opened on the second postoperative day, and stool was passed from it on the fourth postoperative day. He was discharged from the hospital on the 14th postoperative day but was readmitted several times during the next few weeks for severe vomiting and pain. This responded well to gastric suction, irrigation of the colostomy, and intravenous fluids. It was about six weeks before this infant could eat well without distress. The colostomy was closed about four months later without any further complications.

Following is the report of a patient with endometrial carcinoma in whom recovery was uncomplicated after surgical repair of a perforation of normal colon during barium enema.

From the Departments of Obstetrics-Gynecology and Surgery, College of Medicine, The Ohio State University, Columbus, Ohio. Submitted October 24, 1961.

*The Authors*

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● Dr. Furste, Columbus, is clinical assistant professor of Surgery, The Ohio State University College of Medicine.

### Case Report

A 55 year old, obese, white, Para III, housewife was admitted to the private medical service at the Ohio State University Hospital on January 25, 1956 for treatment of uncontrolled diabetes mellitus. She had been a known diabetic since 1947 and had been requiring an average daily dose of 40 units of Protamine Zinc Insulin up to November, 1955. Thereafter the need for Protamine Zinc Insulin increased until she was taking 85 units daily at the time of hospital admission.

A gynecological consultation was requested, when she gave a history of having had pink vaginal discharge since October, 1955. She had never taken estrogens in any form though she had been experiencing moderate "hot flashes." Very heavy metromenorrhagia had occurred for five years prior to her menopause in December, 1954. Although she was the sister of a physician, she had never sought medical advice for the premenopausal flooding or the postmenopausal spotting. A diagnostic dilatation and curettage was recommended to eliminate the possibility of endometrial carcinoma despite a negative Papanicolaou vaginal smear for malignant cells, which had been done when she was first examined in the hospital.

On January 31, 1956, examination under anesthesia

showed the cervix to be free of erosion and the uterus to be only slightly enlarged and freely mobile. No masses were felt in the vaginal vaults. A small amount of endometrial tissue was obtained by curettage, and the histologic diagnosis was endometrial adenocarcinoma.

Treatment of this endometrial carcinoma was deferred for several days in order to stabilize the diabetes and essential hypertension in this obese patient. It was planned to deliver 5,500 r of radioactive Cobalt 60 to point A in the pelvis followed by a total abdominal hysterectomy and bilateral salpingo-oophorectomy about six weeks later.

On February 8, 1956, a tandem and colpostat containing radioactive Cobalt 60 was inserted into the uterine cavity. An ionization chamber was inserted into the rectum through a sigmoidoscope to check on the gamma radiation reaching the bowel. Roentgenograms taken at this time showed the tandem and colpostat to be properly placed with the ionization chamber lying in the rectum. Four hours later a barium enema was administered to this patient and barium iodide was instilled into the bladder to check the position of the radioisotopes. The roentgenograms demonstrated large amounts of barium sulfate present in the left side of the peritoneal cavity indicating an intra-abdominal perforation of the colon.

After the roentgenograms were read, the patient was immediately re-evaluated. She was complaining at this time of moderate right shoulder pain in addition to a slight amount of diffuse lower abdominal discomfort. The blood pressure was 150/100 and her pulse was fairly strong and regular with a rate of 110 per minute. No marked abdominal tenderness or rigidity were noted.

Approximately two and a half hours after the barium enema had been given, an emergency laparotomy was done. Prior to the laparotomy, the vaginal pack and applicators containing the radioactive Cobalt 60 were removed. Intra-abdominal inspection revealed a large amount of barium sulfate spread throughout the abdominal cavity. The abdominal cavity was flushed with about 5,000 cc. of physiological saline solution in an attempt to dilute the barium. Then, as much barium as possible was removed by aspiration. Further inspection revealed a 2 centimeter, irregular, perforating laceration in the anterior wall of the sigmoid colon just above the rectosigmoid junction. This rent was closed with two layers of interrupted 00 silk. This was followed by a temporary transverse loop colostomy and total abdominal hysterectomy with bilateral salpingo-oophorectomy. The vault of the vagina was left open.

A hematoma was noted in the broad ligament after the rent in the sigmoid was repaired. It was then that the decision was made to do a total abdominal hysterectomy and bilateral salpingo-oophorectomy leaving the vault of the vagina open, rather than to attempt finding and ligating the bleeding points in the broad ligament. It was felt that the hysterectomy, with only a slight increase of surgical risk, would not only be an effective cure for the clinical stage 1 endometrial carcinoma but also would afford an excellent means of extraperitoneal drainage, in case there had been some further unrecognized retroperitoneal injury to the bowel. It was felt that the temporary transverse loop colostomy would aid in recovery by preventing further intra-abdominal fecal leakage from the site of the repaired rent in the sigmoid by minimizing the possibility of colon distention and paralysis.

The colostomy was opened immediately. Two million units of penicillin was instilled into the abdominal cavity, which was then closed in layers. Four retention sutures were used. No drains were inserted. Anesthesia was accomplished with Pentothal® and curare supplemented by cyclopropane and oxygen. The blood pressure was somewhat unstable near the end of the surgical procedure, but this responded to the use of Levophed® tartrate and a 500 cc. blood transfusion. She was returned to her bed from the recovery room about one hour after the operation was completed.

The postoperative course was most uneventful. There was practically no elevation of temperature, and no abdominal distention occurred. The colostomy began to function on the third postoperative day. At no time in the postoperative course did she show acidosis. The need for insulin became progressively less. Her diabetes was controlled by a diet of carbohydrate 160 Gm., protein 80 Gm., and fat 80 Gm. and an average of about 30 units of insulin a day. She was given penicillin 300,000 units and streptomycin 0.5 Gm. intramuscularly twice daily for one week postoperatively. She was discharged from the hospital on February 17, 1956, the tenth postoperative day.

Secondary closure of the colostomy with complete mobilization of the colostomy loop was effected on April 13, 1956. She received Sulfathalidine® 2 Gm. three times a day for bowel preparation for 12 days before this operation. Here again, her postoperative course was uneventful. She had bowel movement on the third postoperative day, and was discharged on the tenth postoperative day.

During the six years following surgery for perforation of her normal colon by a barium enema, this patient has been followed closely. Her medical history, up to the time of her last physical examination in October, 1961, has been unremarkable. Her chief complaint at this time was her inability to keep her weight down to normal levels. Her diabetes mellitus is controlled adequately by diet and oral medication of Orinase.® Her blood pressure did reach 220/110 in 1958 but was only 174/90 at the time of her last office visit. She had experienced one episode of moniliasis vaginalis, which responded readily to local therapy. Repeated pelvic examinations during the past six years have shown no evidence of recurrence of endometrial carcinoma, and Papanicolaou vaginal smears have remained consistently free of malignant cells. No bowel disorders have been noted since surgery.

## Discussion

The absence of postoperative complications after large amounts of barium entered the abdominal cavity through a perforation of the sigmoid, suggests that barium is in itself a benign substance. This case report further suggests that complications and fatalities in cases such as this, would be from peritonitis due to unsterile colon feces rather than from the barium with which it was mixed.

## Summary and Conclusions

An uncomplicated surgical recovery following the perforation of a normal colon by a barium enema, is presented as a case report. The perforation of the normal bowel occurred in a 55 year old white woman with a clinical stage 1 endometrial carcinoma, exogenous obesity, diabetus mellitus and hypertensive heart disease.

Emergency surgery was done approximately two and a half hours after the colon was perforated by a barium enema. Surgery consisted of closing the rent in the sigmoid, a temporary transverse loop colostomy, a total abdominal hysterectomy and bilateral salpingo-oophorectomy. The postoperative course was uncomplicated. Secondary closure of the colostomy with complete mobilization of the colostomy loop was done about two months later. Again, her postoperative course was unremarkable.

No untoward after-effects of the perforation or of the corrective surgery have been noted during the past six years. There has been no evidence of recurrence of the endometrial carcinoma.

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Heart Page

# The Clinical Evaluation of the Heart

## II. The Normal Second Heart Sounds

DANIEL K. BLOOMFIELD, M.D.*

NO SINGLE feature of auscultation is more closely identified with modern cardiology than careful analysis of the splitting and intensities of the second heart sounds. The utility of these sounds, which literally have been right before our ears, has long been overlooked. The older division of auscultatory areas into aortic and pulmonary has led to a confusion that is difficult to overcome. The terms $A_2$ greater than, equal to, and less than $P_2$ are rarely helpful and frequently misleading. In describing heart sounds our aim is to describe precisely the closure of the aortic and pulmonary semilunar valves, which I shall label with superscripts as $A^2$ and $P^2$ respectively, to avoid confusion with previous notations.

The first important point to appreciate is that $A^2$ may be heard almost anywhere over the precordium and not necessarily best in the "aortic" area. Keep in mind that the so-called mitral second sound is, with few exceptions, $A^2$; and it follows that $A^2$ is frequently heard best at the *apex*. This is particularly true in the older age groups. Most important of all is that $A^2$ is well heard in the pulmonary area, where it is easily distinguished from the later $P^2$. Analysis of the second heart sounds is impossible unless this is appreciated. The second heart sound in the pulmonary area is "split" into an earlier aortic and later pulmonary component. The split is maximal at the end of inspiration because inspiration increases right ventricular filling and prolongs right ventricular ejection. This delays pulmonary closure and $P^2$. Left heart filling is not affected to this degree so that aortic closure is nearly constant in timing. The net effect in the pulmonary area is a second sound which splits on inspiration and is single or "closes" on expiration as $P^2$ moves back and forth from the stationary $A^2$.

How does one hear a split? The split, like all of auscultation requires tuning rather than gain. It is audible to most ears. If you have never heard a split, take it on faith that any normal person under the age of 30 has an easily identified split, and listen in the pulmonary area until you hear it. The best teaching aid I know is the telephone, since both the ringing and busy signals (at least in the Cleveland area) have clearly split "second sounds." Parenthetically, a fine "ejection click" is heard after the "first sound" but that is subject for another time. Having mastered the splits of young people and/or telephones, one will observe normal splitting in three fourths of all adults. The sounds in older patients, particularly those with increased chest diameters are frequently best identified farther down the left sternal border. One word of caution in trying new auscultatory techniques is that patients frequently become anxious when the doctor's stethescope spends more than a cursory amount of time in the cardiac area of the chest and reassurance is frequently necessary.

In listening for the split, one should focus so completely on the second heart sound that nothing else in the heart and chest are heard. I have sometimes been asked to evaluate only a split and upon leaving the bedside was completely unable to answer the afterthought inquiry of how I interpreted a murmur. This applies to all auscultation: one sound or one murmur at a time.

Technically there is little difference between bell and diaphragm in listening to the second sound. It is heard well with either, although this may vary from patient to patient. It should be emphasized that the respiratory changes described are heard with *normal* respiration and once the patient is conscious that his breathing is being observed or is requested "breathe in" or "breathe out" the second sound will invariably be more difficult to analyze. With proper concentration and tuning on the second sounds, breath sounds of normal respiration will hardly be heard and should not interfere.

This summary has concentrated only on the normal second heart sounds. A few moments practice with each patient will soon make them "second nature." The normal will contrast with the abnormal and add considerably to diagnostic and prognostic skill. "The second heart sound is of normal intensity and normally split" tells a story that cannot be matched by "$A_2$ is equal to $P_2$." This becomes much more apparent and clinically useful in the pathological states which will be discussed next.

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The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

*Dr. Bloomfield, Cleveland, Senior Instructor in Medicine, Western Reserve University School of Medicine, is an Established Investigator of the American Heart Association.

# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT P. CARSON, M. D., *President*

### PRESENTATION OF CASE

THIS was the fourth admission to the Hematology Service for a 10 year old white boy, who entered with a 36 hour history of midabdominal pain, anorexia, vomiting and fever. The day prior to admission he had awakened complaining of abdominal pain that recurred in "waves" every five minutes. He was anorectic, vomited clear liquid one time, and passed a small, normal appearing stool. During the day the pain became steady and aching, and the boy gained most relief by lying on his side with his legs drawn up. On the morning of admission he complained of constant lower abdominal pain, his abdomen appeared distended, and he vomited greenish material on one occasion. His temperature was 101.5°F. He was seen by his family physician and referred to University Hospital for further treatment.

The patient had been first admitted nine months previously with symptoms of intermittent fever, anemia and growth failure. A diagnosis of congenital ovalocytosis with hypoplastic bone marrow and pancytopenia was made. A chromium 51 red cell survival showed decrease in red cell half-life. Two other members of his immediate family were known to have ovalocytosis. The boy received a transfusion and was discharged after a stay of three months in the hospital. He was again admitted with recurrent anemia and leukopenia. His red cell survival time remained low. The patient underwent splenectomy and had a liver biopsy and appendectomy. He did well until three months before his final admission and at that time he was again admitted for transfusion because of anemia. Five days prior to his fourth and final admission he was seen as an outpatient, was found to have a hemoglobin of 8.8 Gm. per 100 ml. and was treated with prednisone, 5 mg. three times daily.

#### Physical Examination

The patient was a small, thin, acutely ill, dehydrated white boy with a distended abdomen, dry mucous membranes and sunken eyes. His temperature was 100.6°F., his pulse rate 144 per minute, respiratory rate 38 per minute, and blood pressure 110/70. His chest was clear. Cardiac examination showed sinus tachycardia with a grade 2 precordial systolic murmur. The abdomen was distended and tight; liver dullness was preserved. The abdomen was diffusely tender; no masses or point tenderness was felt. Bowel sounds were present but hypoactive. Rectal examination showed tenderness in all quadrants but no masses. Stool guaiac was negative.

Submitted July 30, 1962.

### *Presented by*


- William G. Pace, M. D., Columbus, and
- Emmerich von Haam, M. D., Columbus.

Edited by Dr. von Haam.


#### Laboratory Data

On admission the patient's hemoglobin was 9.8 Gm.; red blood cell count was 3.53 million, the white blood cell count 6,500 with 40 per cent neutrophils and 60 per cent lymphocytes; the platelet count was 896,000; there were 16 per cent reticulocytes. The urine had a specific gravity of 1.026, contained 50 mg. of protein per 100 ml., and had 4 to 6 white blood cells per high power field. The blood urea nitrogen was 19 mg. per 100 ml. The serum sodium was 137 mEq., potassium 6.0 mEq., chlorides 94 mEq., and $CO_2$ combining power 26 mEq./L. Prothrombin time was 57 per cent.

X-ray of the abdomen showed loops of the bowel filled with fluid with a scattered gas pattern and multiple fluid levels in the upright position. His chest film was normal.

#### Hospital Course

Shortly following admission the patient began to complain bitterly of increase in abdominal pain. He became hypotensive with faint, thready pulse and had emesis of a small amount of bile-stained material. His blood pressure responded well to a unit of dextran. A Levin tube was passed and 1200 cc. of bile-stained material was removed from his stomach

with some relief of his distention and respiratory difficulty. A Foley catheter was passed but only 10 cc. of concentrated urine was obtained. Over the next six hours the patient was given 500 cc. of plasma, 500 cc. of whole blood, 1000 cc. of 5 per cent dextrose/normal saline, and 300 cc. of M/6 sodium lactate. His urinary output increased to approximately 15 cc. per hour. His blood pressure remained stable but his pulse rate remained elevated to 150 to 160, and respirations increased to 40 to 50 per minute. His temperature was 101.8°F. recently. Suddenly, 12 hours after admission, the patient became dusky with labored respiration; his blood pressure and pulse became unobtainable. Artificial respiration was to no avail and the patient died.

## CLINICAL DISCUSSION

DR. PACE: We have a 10 year old boy here who had been sick for about 36 hours before his admission. He awakened with crampy pains on the day before he came in, which obviously means intestinal obstruction and which is a little bit unusual for a 10 year old except that he had had previous surgery. That, however, might be a part of a clue to the cause of his intestinal obstruction. The pain progressed within the morning and became steady during the day. It is a little unusual for intestinal obstruction to go that fast from the obstructive type to that of peritonitis.

He was described as lying on his side with his legs drawn up, relaxing his psoas and his abdominal musculature, which is a very typical position of a patient who has generalized peritonitis. From that moment on, he had no more cramping pain or his pain would not have been relieved by this position. So his illness had progressed rather more rapidly than you would expect from most of the usual types of obstruction except in a case of a closed loop obstruction with rapid infarction of a segment of bowel, which occurs in this age group usually as a consequence of appendicitis. His temperature at admission to the hospital did not amount to much, but he was very sick and had been sick with peritonitis for at least 24 hours before he came into the hospital.

### Abnormal Red Blood Cells

His past history is full of red herrings and if it were not there it would make this case fairly easy. This boy had been in three times before, the first time nine months before, when the diagnosis of anemia with congenital ovalocytosis was made. Any patient with progressive anemia can show a certain degree of ovalocytosis, which is purely secondary and just a manifestation of poikilocytosis. If the patient had the primary congenital elliptocytosis that Dresbach described in 1904, I am a little surprised to find that he had a hypoplastic bone marrow and pancytopenia, which is not supposed to go along with this condition.

Usually congenital ovalocytosis is just an incidental finding of odd-shaped erythrocytes on a peripheral smear and occurs in about 0.04 per cent of the population, but only one out of eight persons will have asymptomatic anemia associated with this condition and of these a much smaller percentage will require and be eventually treated with splenectomy. I estimate the incidence of such an event as approximately 1 out of 150,000 or 200,000 persons.

A non-response to splenectomy in a patient with anemia due to ovalocytosis is supposed to be so rare that I could not even find anything written on it, and I suspect that is why he is the subject of this clinicopathological conference. Be this as it may, I don't think that his blood disease contributed much to his present picture except that he had had a splenectomy for it. That, I do think might be important. He had an appendectomy at the same time which, unless there was an appendiceal stump left behind, rules out the likely diagnosis that you would suspect from the description of his terminal illness. The patient apparently had continuing anemia even after his splenectomy and had been treated for it just recently with prednisone.

### Low White Blood Cell Count

In his physical examination on admission there is nothing particularly significant. He was a sick little boy who was dehydrated, had marked abdominal distention and minimal fever. His tachycardia was probably the most striking finding. He did not have free air in the peritoneal cavity and therefore probably had no free intestinal perforation. I presume we were ruling out a perforation of a duodenal ulcer or something to that effect from his steroid therapy. His laboratory data were compatible with ovalocytosis, and his white blood cell count was surprisingly low in the face of the overwhelming intestinal or abdominal catastrophe that he had. He had a reticulocyte count of 16 per cent and almost a million platelets, which I can't reconcile with a hypoplastic bone marrow that he was reported to have had earlier. The only way that I could possibly explain this is on the basis of a dramatic or beautiful response to steroid therapy, although in reviewing the literature of ovalocytosis I could find nothing on the effect of steroids.

His pain remained essentially the same until he had been in the hospital for a while, and then he began to complain bitterly of an increase in pain. Why this sudden change? What would give this marked increase? Maybe it was the trip to the X-ray Department. I don't know. But he became shocky at that time and had a thready pulse. They put in a unit of dextran and removed 1200 cc. of fluid from his stomach. That is a pretty fair amount of fluid and I am sure could initially have caused some of his shocklike picture. In spite of intensive treatment he continued to show a progressive shocklike picture, increasing abdominal distention and labored respirations and died.

Summarizing this case then, we have a little fellow who has a relatively benign blood disease for which

he had been treated with a splenectomy and failed to respond. He came into the hospital with a relatively short episode of intestinal obstruction which progressed almost explosively to peritonitis, and then after he got into the hospital he got much worse with increasing pain beyond the generalized peritonitis that he had before. The so-called "closed loop" obstruction could do this with a rapid necrosis of a segment of bowel, whereas the simple obstruction by band adhesions hardly could explain why the intestinal obstruction pain was followed so quickly by peritonitis. The most common closed loop obstruction in children is of course appendicitis, which we can safely rule out here. Also another possibility is a Meckel's diverticulum, although I assume this would have been noted at his laparotomy.

We do have a platelet count here of close to a million, and he was quite a while after a splenectomy. The usual immediate response to splenectomy is a rise of platelets up to two million or so, which is not ordinarily associated with multiple thrombotic problems although such has been reported. The fact that it can occur leaves the possibility that he may as a consequence of his vomiting and dehydration have developed a mesenteric infarction from thrombosis either of the mesenteric artery or mesenteric vein.

### Mesenteric Thrombosis?

Now another diagnosis which would fit perfectly well would be an initial thrombosis of a branch of the mesenteric artery with a localized infarction of small bowel, which would give the pattern of intestinal obstruction, and then, with necrosis of the small bowel at the point of infarction, would go on relatively rapidly to generalized peritonitis because of the dissolution of the bowel wall and release of intestinal contents into the peritoneal cavity. Finally, a total mesenteric thrombosis would explain the marked increase in pain which he had terminally.

A likely and also a very excellent possibility would certainly be perforation of a duodenal ulcer with essentially the same course of events leading up to the patient's death. Another rare and much more remote possibility, I suppose, would be the occurrence of gallstones, which has been reported in association with hereditary elliptocytosis, with an acute cholecystitis and perforation of the gallbladder.

Dr. von Haam: We have a very interesting case here before us. He was in the hospital only a short time, but the patient was well known to us and well studied. I have asked Dr. Wilson, who is an expert on elliptocytosis, to discuss this condition in connection with this patient.

Dr. Henry E. Wilson: I saw the child once, I think, because he posed this very interesting phenomenon of elliptocytosis. You could debate whether or not this was congenital. I believe his father and one sibling had the disease. That is pretty hard to argue with. This child also had what we call bone marrow hypoplasia. The question came up whether you ever get hypoplastic anemia with hereditary elliptocytosis. I don't think that ever occurs, and to my knowledge in the 360 odd cases of elliptocytosis that have been reported, it has never been reported. At any rate, we postulated that he had two separate hematologic conditions: hereditary elliptocytosis, and some type of bone marrow depression completely unrelated to his congenital anomaly.

Elliptocytosis should be of interest to the surgeon, and I don't see why you should overlook it because of its rarity. The first patient I saw walked into my office yellow as saffron with acute cholecystitis and cholelithiasis. Many of these people do have gallstones, as in any other hemolytic phenomenon. The crux of the issue, I think, apart from any connection with this case, is that it throws some light on the pathogenesis of one type of hypersplenism. All the patients that we studied showed a moderate degree of anemia and after splenectomy you can see a lot of micro-elliptocytes which were previously filtered out by the spleen.

Of course the platelet count goes sky-high after splenectomy. The improved counts after splenectomy could conceivably reflect a marked improvement in the bone marrow function. There is quite a literature now being accumulated of carefully studied cases of well documented marrow hypoplasia in which splenectomy is followed by a brilliant return of activity on the part of the marrow, and some people have postulated that it looks as though splenectomy does something specific to enhance improvement of the bone marrow.

Dr. von Haam: Thank you very much, Dr. Wilson. Dr. Pace, you felt very definitely that mesenteric thrombosis played a part, didn't you?

Dr. Pace: Yes, I think that was the terminal event. The primary thing may well have been also a segmental thrombosis with obstruction due to that.

### CLINICAL DIAGNOSIS

1. Congenital elliptocytosis.
2. Segmental thrombosis of small intestine with obstruction and peritonitis.
3. Massive terminal mesenteric thrombosis.

### PATHOLOGICAL DIAGNOSIS

1. Polyarteritis nodosa with thrombotic microangiopathy.
2. Congenital elliptocytosis.

### PATHOLOGICAL DISCUSSION

Dr. von Haam: The autopsy showed numerous fibrous adhesions over the liver, intestines and abdominal wall. There was 300 cc. of sanquineous fluid present, and the peritoneal surfaces of the intestines showed some fibrinous exudate. The pericardial surface showed a few petechiae. The small intestine showed focal areas of blackish-blue dis-

coloration with numerous mucosal petechiae scattered throughout the intestines. The left gastric artery as well as the peripheral branches of the mesenteric arteries and veins was occluded by recent thrombi. The liver and pancreas appeared grossly normal. The kidneys were congested and showed recent thrombi of the smaller intrinsic vessels.

Microscopic sections of the heart showed severe arteritis involving the medium-sized and small branches of the coronary vessels. The arteritis involved the entire thickness of the vessel wall, causing in some areas a rather severe infiltration of the adventitia. Some of the smaller vessels were occluded by recent thrombi. Similar but less pronounced changes were present in the lungs.

The vessels of the abdomen showed pronounced lesions of periarteritis and endarteritis with thrombosis and severe destruction of the vessel wall. The thrombi proved to be of different ages, some being recent, others in a stage of organization. This vascular lesion was accompanied by patchy necrosis of the mucosa and muscularis of the small and large intestines and areas of necrosis in the liver and pancreas. Many of the smaller branches which did not show the arteritic changes were occluded by fresh platelet thrombi. In some vessels fibrosis of the intima and media was present with the formation of microaneurysms. The same arteritic lesions were also observed in the adrenal and kidney accompanied by foci of ischemic necrosis in both organs. The medium-sized branches of the mesenteric vessels showed similar changes. In a few areas the vessels of the skin were studied and again showed changes of periarteritis, arteritis and thrombosis. These changes, however, were much less pronounced than those involving the vessels of the abdominal organs.

In conclusion, we felt that the patient suffered from a recently acquired collagen disease which formed a picture of periarteritis nodosa and thrombotic angiopathy. The latter is probably similar to thrombotic thrombocytopenic purpura, which also falls into the group of autoimmune disorders. Although the boy suffered from widespread periarteritis nodosa, he presented only symptoms resembling an acute abdominal catastrophe. I feel certain that the severe involvement of the coronary vessels contributed heavily to his rapid demise. It is not frequent that periarteritis nodosa produces symptoms of acute surgical catastrophe, but it has to be considered in the differential diagnosis of all cases of mesenteric thrombosis, particularly in a young individual.

The ovalocytosis, which could be demonstrated again in blood taken at the autopsy, played no part in his present condition. Examination of the bone marrow showed a rather active marrow with myeloid and erythroid hyperplasia. We feel that the anemia was due to a hemolytic component in an autoimmune disease similar to the anemia observed in thrombotic thrombocytopenic purpura.

## Franklin County Pelvic Cancer Delay Committee Report

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee at its July 18, 1962 meeting.

Case Number 104: The patient is a 48 year old white woman, gravida III, Para 1, abortus II, who had been seeing her family physician because of pelvic relaxation and a slightly suspicious Papanicolaou smear. Her past history is noncontributory except for her menstrual history which reveals that she had spontaneous menopause three years ago. Two years later in May, she began having menstrual periods which were somewhat irregular. Shortly thereafter vaginal bleeding was completely regular and was described as almost constant bleeding through November. A Papanicolaou smear, taken at this time, was reported as slightly suspicious and without any further preoperative diagnostic study, a vaginal hysterectomy and anteroposterior repair was done on December 6. The pathology report of the removed tissue revealed squamous cell carcinoma of the cervix with tumor extending through the outer margin of the vaginal wall resection. The patient was subsequently referred to University Hospital for further treatment. At this institution, she received 7500 roentgens by cobalt teletherapy.

### Comments

The most common cause of postmenopausal bleeding is carcinoma of the cervix or endometrium. This patient had spontaneous menopause 18 months before subsequent vaginal bleeding which in itself, excluding the Class II or III Papanicolaou smear, indicated a diagnostic dilatation and curettage and cold knife conization of the cervix to rule out a malignant tumor of the uterus.

Furthermore, there is no substitute for a thorough pelvic examination before hysterectomy to rule out any co-existing problems which may necessitate a change in the elective surgical procedure. In conclusion, this case demonstrates three violations of important principles governing hysterectomy: (1) Excluding a thorough pelvic examination; (2) Disregarding the report of a suspicious Papanicolaou smear, and (3) Omitting a diagnostic dilatation and curettage and cold knife conization of the cervix.

*Patient Delay:* None.

*Physician Delay:* Seven Months.

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## Hypophysectomy in Advanced Breast Cancer

Pituitary ablation has been performed on 111 unselected patients with disseminated carcinoma of the breast over the past five years—104 by surgical hypophysectomy and 7 by stereotaxic procedure. Regression or arrest has occurred in 42 per cent of the patients assessed and the average expectation of life was increased by 12 months. A favorable response was more likely in patients who had responded well to previous endocrine therapy, and those in whom there was a long interval between the primary disease and the appearance of metastases.—*British Medical Journal,* 5255:790-793, September 23, 1961.




# NEWS AND Organization Section

## Emergency Room Ruling

### Attorney General Holds Hospital Plan of Charging Fee for Services by Salaried Physician Is Unlawful

A HOSPITAL may maintain an emergency room and may, as a charity, make available in connection with such room the services of a licensed physician; **however, when a hospital, in connection with the operation of an emergency room, charges a fee for the professional services of a licensed physician and said physician is paid a salary by the hospital for his services, such hospital is engaged in the unlawful practice of medicine,** according to an opinion (No. 3197) handed down on August 10 by Attorney General Mark McElroy.

The opinion also pointed out that a physician employed by a hospital under an arrangement as described above, because of the division of professional fees for his services, would be guilty of grossly unprofessional and dishonest conduct as described in Section 4731.22 of the Revised Code (the Medical Practice Act), and his medical certificate would be subject to revocation.

#### Question from Greene County

Attorney General McElroy's opinion was issued in reply to a communication from the Greene Memorial Hospital, Xenia, to the prosecuting attorney of that county who in turn sought the advice of the attorney general, which communication read in part as follows:

"The Board of Trustees of Greene Memorial Hospital would like to request you to request an opinion from the Attorney General of the State of Ohio as to the legality of placing a physician on the Hospital's payroll. Briefly, this is the information: We have employed a young physician from Wright Patterson Air Force Base who is licensed in the State of Ohio and completed his studies at Western Reserve in July of 1961.

"This individual cannot go into private practice as long as he is with the Air Force but due to the fact that he is not in the clinical aspect of medicine, he applied for a position at Greene Memorial to take call in the Emergency Room and also to treat those patients under the supervision of the admitting physician.

"When he treats these patients, the Hospital makes a charge to the patient of $5.00 in addition to the Emergency Room rate and this is called a professional fee. Hence, the opinion needed is may the hospital legally charge an additional fee over the Emergency Room rate for professional services rendered by the Doctor, which we collect and deposit in our Operating Fund, and, if so, are we engaging in the practice of medicine.

"This physician receives a salary of $110 per month for his services from the Hospital's payroll. He is not a member of the Medical Staff but is considered, in our opinion, an employee taking medical directives for the services performed from the Active Staff and Administrative directive from the Hospital.

"The primary purpose of placing this physician on the payroll is to render better Emergency Room coverage for the Community. A $5.00 fee is charged and put in the Hospital's Operating Fund out of which his salary is paid. There is no motive for profit or gain involved."

#### Cites Previous Opinions

In his opinion, McElroy cited two opinions of the attorney general — No. 1751 in 1952 and No. 3031 in 1962 — upholding the principle that a corporation organized for profit or not for profit may not engage in the practice of medicine and that a hospital would be engaging unlawfully in the practice of medicine if

a fee is charged by the hospital for medical services performed by hospital employees.

### Can't Be Termed Charity

Concerning the question at issue in Greene County — that of emergency room services, the opinion had this to say:

"The emergency room of a hospital is perhaps the most dramatic example of the charitable nature of a hospital. There can be no question that the services of the emergency room are provided in order that the public, indigent or otherwise, may have available to it in times of emergency the facilities and equipment of such hospital. An emergency room, as such, does not violate the basic principle that a hospital may not practice medicine.

"It may be considered necessary to the maintenance of an emergency room that a trained physician be available to render service to the persons who find it necessary to seek emergency aid. As can be seen by the above quoted matter, the prohibition against the unlicensed practice of medicine does not exclude the performance of an act of charity. Accordingly, where the hospital is providing as a charity, medical service in connection with the operation of its emergency room, there is no unlawful practice of medicine.

"Applying this theory to the facts set forth in the letter of Greene Memorial Hospital, I am unable to conclude that the medical services given in connection with the operation of such emergency room can be considered a charity in light of the fact that the hospital levies a fee of $5.00 for such services. The charging of such a fee is totally inconsistent with the theory of charity.***

"It should also be pointed out that the practice of medicine without a certificate of the State Medical Board is, pursuant to Sections 4731.41 and 4731.99, Revised Code, a crime. One who commits the crime of practicing medicine without a license, is, as a general rule, precluded from recovering compensation from his 'patient' for his services, 42 Ohio Jurisprudence 691, Physicians and Surgeons, Section 168. It would, therefore, appear that Greene Memorial Hospital would not be entitled to recover the $5.00 fee charged to the patient for professional services as a result of the use of the emergency room."

### Three Conclusions

In concluding, the opinion presented the following syllabus:

1. A hospital, including a county hospital established pursuant to Section 339.01, *et seq.,* Revised Code, may not practice medicine.

2. A hospital may maintain an emergency room and may, as a charity, make available in connection with such room the services of a licensed physician; however, when a hospital, in connection with the operation of an emergency room, charges a fee for the professional services of a licensed physician and said physician is paid a salary by the hospital for his services, such hospital is engaged in the unlawful practice of medicine.

3. Said physician, when employed by such hospital under such arrangement, because of the division of professional fees charged for his services, would be guilty of grossly unprofessional and dishonest conduct as described in Section 4731.22, Revised Code, and his medical certificate would be subject to revocation.

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The Veterans Administration will put fallout shelters into six of its hospitals including the one in Cleveland. The shelter space will be in regular use for normal hospital activities, VA announced.

## New Dean Named for Cincinnati College of Medicine

Newly appointed dean of the University of Cincinnati College of Medicine is Dr. Clifford Grosselle Grulee, Jr., acting dean and director of the Division of Graduate Medicine at Tulane University School of Medicine, New Orleans. He will assume his new duties January 1.



Dr. Grulee

Dr. Grulee succeeds Dr. Stanley E. Dorst, who announced his retirement after a lifetime of work in medical education including the post as dean of the College of Medicine since 1940.

The College of Medicine is a major unit in the Medical Center which also includes the College of Nursing and Health, Cincinnati General Hospital, Christian R. Holmes Hospital and Kettering Laboratory. Dr. Clement F. St John, University of Cincinnati vice-president, is director of the Medical Center, and headed the committee which nominated Dr. Grulee for the deanship.

Dr. Grulee received a bachelor of arts degree in 1933 from Williams College, Williamstown, Mass., and a doctor of medicine degree in 1938 from Northwestern University, Evanston, Ill. He interned at St. Luke's Hospital, Chicago, and was a resident at Boston Children's Hospital, 1938-1942.

Before going to Tulane in 1950, Dr. Grulee was associated with Harvard University, 1938-1942; held a Rockefeller fellowship for research in pediatrics at the University of Minnesota, 1946-1947; and was on the medical faculty at the University of Texas, Austin, 1947-1950. During World War II he served with the U. S. Air Force, acquiring the rank of captain.

A diplomate of the American Board of Pediatrics, Dr. Grulee is a member of the American Pediatric Society, Society for Pediatric Research, Academy of Pediatrics, American Medical Association, and Association of American Medical Colleges.

Dr. Grulee is married to the former Miss Mary Evelyn Lewis. They have a son, Clifford Grosselle III. They live at 110 Mulberry drive, Metairie, La.

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## Attorney General Issues Opinion

Attorney General Mark McElroy, in an opinion to John G. Peterson, prosecuting attorney of Greene County, held that employees of a county hospital may not be granted discounts on rates when they become patients of the hospital. McElroy noted that the power to grant such discounts has not been given by law to boards of trustees of county hospitals.

# Listen... Read... Look... Talk... Argue... Think...Work...Then Vote on November 6




Here are seven "basics" of citizenship which are recommended for every physician who takes his civic responsibilities seriously:

—The doctor's primary duty as a citizen is to be the guide and source of authority in all health matters relating to his community. This is an all - year - round civic responsibility, which his training and experience have qualified him to handle better than any other person in the community.

—The doctor should openly identify with the party of his choice, and vote regularly at all elections.

—The doctor should make an investment in democracy by contributing liberally financially to the party of his choice.

—The doctor should encourage patients and others with whom he comes in contact to register and vote in all elections.

—The doctor should keep informed on candidates and issues and let others know where he stands politically.

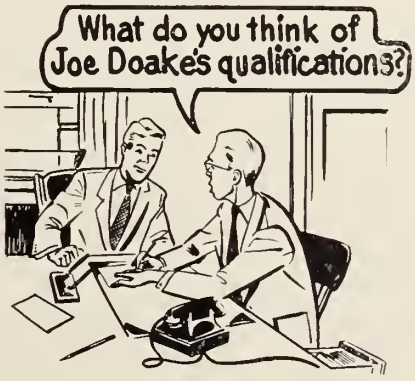
—The doctor can help candidates of his choice by such means as displaying campaign literature in his waiting room.

—The doctor should devote as much time as his professional duties permit to working for good government and for the political party of his choice.

"Candidates don't win elections. Organized personal efforts at the voter level and vigorous man-to-man persuasion are decisive. Elections are not won on the stump or on the TV screen. They are won at the front door of the voters and at the roadside in the country and at the workbench in the factory. For the women it should be added that elections are won also when they drop in on their neighbors and chat. It is a well-known fact that personal contacts, and personal contacts alone, are the final means of delivering the vote.

"The fight against statism cannot be won by the timid and noncommittal. People must forego convenience and security from criticism. They must get into politics, despite the consequences. Citizen action must be militant.

"The business or professional man or woman who decides to engage in political activity, in fact any beginner in politics, must learn one lesson above all others. There is absolutely no substitute for personal, face-to-face contact with the voter. In our complex life outside the realm of politics we have the habit of delegation, of contacts by telephone, telegraph, and letters, of dependence upon advertising, publicity releases, and other forms of printed persuasion, or speeches. But in politics, where the final and indispensable act is the voter at the polling place casting the vote, there is nothing that can be substituted for personal contact." — RAYMOND MOLEY.



# Public Health in Ohio...

## State Health Director Outlines Challenges That Are Facing Local Commissioners

PUBLIC health in Ohio must have more funds, more laws and more personnel if it is to meet the challenges it faces, State Health Director Ralph E. Dwork, M. D., told the 43rd annual Ohio Health Commissioners Conference in Columbus September 5.

In his annual address to the conference, Dr. Dwork said that over the past year, there was a "tremendous amount of 'status quo' in public health," in which the forces of public health are "wearing themselves out in holding the line."

He listed as some of the major problems in the public health field: foods processed for home use, home service needs of elderly people, nutrition, inadequate fluoridation of water supplies, continued operation of small tuberculosis hospitals that are no longer needed, and better and more prompt registration of vital statistics.

### Too Many Districts

He said Ohio has too many local health districts for either economy or efficiency, noting that 166 operating health departments are directed by 128 health commissioners, with only 67 on a full-time basis.

Dr. Dwork reported that local per capita appropriation for public health in 1962 was $1.52, two cents over 1961. He expressed doubt that this increase was sufficient to cover monetary inflation, adding that it does not meet the need for necessary new programs, or growth in population.

He reported slight improvement in the ratio of public health nurses to total population, the 1962 rate being one per 6,806. He said Ohio needs 900 additional public health nurses to reach the recommended goal of one per 5,000 population. He said the improvement in industrial health nurses per number of employes was considerably greater.

The State health director said the new needs for public health nursing primarily are in the fields of chronic illness and aging, particularly patients who are to be cared for in nursing homes and in their own homes.

He described as a very important piece of legislation passed by the General Assembly in 1961 a measure enabling local health departments to charge fee for certain public health nursing services in the home. He said similar legislation might be considered with respect to other public health personnel in a coordinated community home care program tied in with private medical care.

### Asks More Subsidy

Other needed legislation as seen by Dr. Dwork included new laws for organization and financing of local health departments, more local health department subsidy from the state, better standards that would be used in judging eligibility for higher state subsidies, and legislation authorizing local departments to institute legal proceedings against health law violators.

He called for a transfer of the crippled children program from the Ohio Department of Welfare to the Ohio Department of Health, a move defeated in the last General Assembly.

Dr. Dwork said that a joint study is being made by the ODH, State Board of Pharmacy, and Ohio Department of Agriculture, as to the possibility of strengthening of existing laws governing supervision of drugs and seeking legal controls over investigational drugs.

Dr. Dwork also asked for consideration of the needs for stronger water pollution, sanitation, milk and meat processing regulations, including statewide supervision of milk and meat processing.

### Resolutions Adopted

Among resolutions adopted by the Health Commissioners Association were those which:

Oppose legislation to transfer the Ohio Tuberculosis Hospital from the Ohio Department of Health.

Support legislation to provide mandatory closure of county tuberculosis hospitals consistently under 50 per cent occupancy.

Support recruitment and training professional health personnel for community services and programs.

Call for additional sources of funds and appropriations for payment of services for the chronically ill.

Establish a health commissioners advisory committee to advise the ODH in developing standards by

## OSMA Issues Official Statement, With Recommendations, On Current Sabin Polio Vaccine Situation

Recommendations of the Ohio State Medical Association regarding the current Sabin oral poliomyelitis vaccine situation were issued September 18 by Dr. George J. Hamwi, Columbus, OSMA president.

Text of the statement, which was sent to county medical society presidents, secretaries and executive secretaries; newspapers, radio and television stations throughout Ohio, is as follows:

"It is the feeling of officials of the Ohio State Medical Association that the evidence to date has revealed no untoward or unexplainable hazard to the administration of Type 1 and Type 2 Sabin oral poliomyelitis vaccine. The evidence for the occurrence of undesirable reactions to the Type 3 vaccine is still questionable and under scrutiny.

"It is therefore recommended that at this time all mass immunization programs be continued with the specification that Types 1 and 2 be administered initially. It is hoped that more concrete and established information will be available by the time that Type 3 is to be given, since this problem is now under intensive investigation by national, state and local experts."

which local health departments may qualify for federal funds.

Ask for legislative appropriations to implement control of radiation hazards in Ohio.

Ask the General Assembly to appropriate to the Ohio Department of Welfare funds to allow adequate payment for services for aid for aged recipients.

The health commissioners also passed a resolution commending the Ohio State Medical Asosciation for its interest in promoting home care programs and its published guide for such programs. The Association recommended appointment of a medical liaison committee to work with appropriate OSMA committees in resolving problems of mutual interest.

### AMA Committee Seeks Comments on JCAH

Comments and suggestions on the operation of the Joint Commission on Accreditation of Hospitals have been invited by the American Medical Association's committee to study operations of JCAH. The new committee was authorized by the AMA's House of Delegates.

Hospital chiefs of staff, hospital administrators and practicing physicians are asked to write directly to Thomas W. McCreary, M. D., the committee chairman, concerning problems encountered in JCAH surveys of their own hospitals. Dr. McCreary's address is 262 Connecticut Ave., Rochester, Pa.

## Ohio Public Assistance in 1961 Totaled $197,823,843

Ohio's six major public assistance programs involved expenditures totaling $197,823,843 during the fiscal year ended June 30, 1962, according to State Auditor James A. Rhodes. This was an increase, he said, of $11 million over the previous year and $25 million higher than two years ago.

The big four were: aid for the aged, $84,048,845, up $2.7 million; poor relief, $50,314,636, down $619,000; aid to dependent children, $46,505,323, up $7 million; aid to the disabled, $12,032,527, up $1.5 million.

The other two assistance programs are: aid to the blind with expenditures of $3,417,320 in fiscal 1962, up $212,525 over the previous year, and aid to crippled children, $1,505,192, up $191,848.

The aid for the aged program continues to be the biggest in amount spent and persons involved, but the aid to dependent children program is growing the fastest. It has increased an average of $7 million a year the last three years.

*Archives of Pediatrics* and the publisher, E. B. Trent & Co., Inc., has been purchased by J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pennsylvania.

# APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1963 ANNUAL MEETING, SHERATON-CLEVELAND HOTEL, CLEVELAND, OHIO, MAY 12-17

1. Title of Exhibit: .....

2. Name(s) of Exhibitor(s): .....

   .....

   Institution (if desired): .....

   City .....

3. Do you have a built-in exhibit? .....

4. Description of Exhibit: **(Attach 200 word description to this blank)**

5. Exhibit will consist of the following: (Check which)

   Charts and posters..... Photographs..... Drawings..... X-rays.....

   Specimens..... Moulages..... Other material .....
   (Describe)

6. Booth Requirements:

   Amount of wall space needed? .....

   Back wall..... Side walls .....

   Square feet needed? .....

   Shelf desired? (yes or no) .....

7. Transparency Cases:

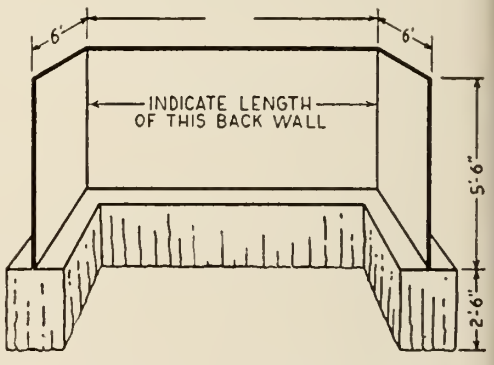
   Needed? (yes or no) .....

   If answer "yes," give following information:

   Number of transparencies to be shown and size of each

   .....

   .....




*Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.*

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit. Ohio State Medical Association" which will be supplied to all applicants.

Date .....

.....
Signature of Applicant

.....
Mailing Address, Street

.....
City, Zone, State

**SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO.**
**DEADLINE FOR FILING APPLICATIONS, FEBRUARY 15, 1963**

# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*
*— Justice Robert H. Jackson in AAA Supreme Court Case, 1942*

### RAP SALES PROMOTION OF DANGEROUS DRUGS

A growing trend among some drug stores is that of promoting the sale of dangerous drugs by name. At its recent annual meeting, the Ohio State Pharmaceutical Association adopted a resolution deploring this as not in the best interests of public health and asking that health organizations join in discouraging such practice. The resolution pointed out that it is the exclusive right of the physician to diagnose and then, if necessary, to prescribe and that the practice of asking customers to influence their physicians to write prescriptions for dangerous drugs is "unneeded and harmful."

The points made are valid. They should have the support of the medical profession.

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### PLANNING FOR YOUR FAMILY'S FUTURE

"It is a common occurrence for physicians to die without a will" writes Bernard D. Hirsh, director of the AMA Law Department, in the *AMA Journal*. How about you? Naturally it's not a joyful subject but, nevertheless, an important one. Write the AMA for a copy of Hirsh's article: It tells all about wills, trusts and estates. Also, it's a guide on how to minimize taxes that may be due at your death. Nothing can be more important than planning wisely for your family's future security.

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### YES — IT'S THE DOCTOR'S BUSINESS, TOO

"Should the medical profession take an active interest in legislative problems which are of special concern to other professions and to those engaged in business and industrial pursuits?"

Obviously, the answer is an emphatic "Yes."

Those legislative problems which are of concern to the High Street merchant also should concern the State Street physician. Both are citizens; both are taxpayers; both are voters; both are interested (or should be) in their community, state and nation, and the welfare of each. Medicine has asked citizens generally to help on the fight against compulsory health insurance. Cooperation is a two-way street. Physicians should consider it an obligation to express views other than those akin to medicine and should look to their fellow citizens in other professions and in business for advice and guidance on such issues.

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### PUBLICITY SPOTLIGHT MIGHT TURN THE TRICK

Editorializing in the *Columbus Academy of Medicine Bulletin* on questionable — even fraudulent — testimony presented by some physicians in Workmen's Compensation cases, P.R.M. tees off as follows:

"There are daily instances of medical testimony and medical opinions which are not responsible and certainly not factual. As loudly and as frequently as we berate the legal profession for obtaining judgements on improbable medical relationships, we must never forget that we are partners in the crime — it takes two to tango.

"It might be well to devote a few pages of the *Bulletin* each month to print verbatim testimony that has been given in court or an opinion which has been rendered on a medical-legal report and invite for contributions. It may well be that if such testimony were given by certain physicians with the understanding that their words would be read and scrutinized by their fellow physicians, more factual medical evidence might be presented."

To which, we say: Amen.

There's nothing like the spotlight of publicity to reveal those who play fast and loose with the truth and in doing so cast shadows on the entire profession. We agree with P.R.M. that it's worth trying.

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### WORK TO BE DONE IN MEDICINE'S RANKS

Writing in *Medical Economics*, Dr. John S. DeTar tells of the tough time which he had before the junior class of Harvard Medical School, when presenting arguments against H. R. 4222 and describing the activities and policies of organized medicine. He points out that some of the students had doubts about

medical practice under a competitive system; approved Federal control of medicine; criticized AMA policy pronouncements, etc.

Dr. DeTar's reaction to all of this is summed up in the following comment:

"I'm now firmly convinced that medicine's leaders have to do more than they're doing in their current campaign to clearly expose all the dangers of Government medicine. They've got to supply more factual evidence. I'm also convinced that if medical care is to remain free from Federal control, today's medical student must receive part of his socio-economic education from teachers who are not committed to collectivism."

Here's something for those who would like to see medicine continue as a free enterprise to think about. There's work to be done within medicine's own ranks.

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### TEN COMMANDMENTS FOR LETTER WRITERS

"Ten Commandments for Letter Writers" is the caption of an article which appeared in a recent issue of the *Ohio State Bar Association Report,* weekly publication of Ohio's barristers.

The article points out that it is vitally important that lawyers take as much time and effort to compose a letter as they do a brief, that both reflect upon their author.

Here are the 10 brief tips on what ingredients the Ohio Bar publication suggests are needed in the drafting of an informative letter:

1. Give some thought to your letter before you start dictating.
2. Be friendly, conversational — write as you talk.
3. Be direct and get to the point without wasting words and time.
4. Be precise and say exactly what you mean without obscure words and double meanings.
5. Write from the other man's point of view, keeping his interests dominant, his intelligence unquestioned, his pride unsullied.
6. Be courteous and polite even when you know he's wrong.
7. Avoid cliches, stilted language and word crutches.
8. Be correct in spelling, grammar and punctuation.
9. End each letter when you've said your piece, bowing politely without scraping.
10. Reread each letter before signing and go over any you wouldn't want sent to you.

We suggest an eleventh: Never dictate in anger. If you do, read the letter after transcription. The chances are that you'll throw it in the waste-paper basket, and having blown off steam, dictate a letter which will conform to the "ten commandments for letter writers." This advice is especially applicable to communications from aggrieved physicians to government agencies, in our opinion.

## Ohio Academy of GP Schedules Headquarters Dedication

A feature of the Ohio Academy of General Practice annual assembly in Columbus will be dedication of its new headquarters building in the Capital City. The Assembly is scheduled Thursday-Saturday, October 18-20, with sessions in the Veterans Memorial Building, 300 W. Broad Street. Dedication of the headquarters building will be at 6:00 p. m. on Thursday, October 18, with an open house following. Sessions of the House of Delegates will be in the Deshler Hilton Hotel.

(See photo of building on front cover.)

The ultra modern two-story structure is located in a suburban area, at 4075 N. High Street in Columbus. It provides increased working space for the staff and for service to the Academy's members. Included in the floor space arrangement are a board of directors room, an all purpose area which will seat up to 175 persons, and several smaller committee conference rooms. Off-street parking is another feature.

Academy officials point with pride to the fact that the Ohio chapter is the only state chapter of American Academy of General Practice to erect its own headquarters. Simplicity of the building lines closely resembles the building which won the grand architectural prize at the Brussels Worlds Fair.

Refer to September issue, page 1041 for details of the annual assembly program.

## Disaster Medical Care To Be AMA Conference Subject

"Survival in the Sixties" will be the theme of the 13th County Medical Societies Conference on Disaster Medical Care in Chicago Nov. 3-4.

To be held at the Palmer House, the two-day meeting is sponsored by the American Medical Association's Council on National Security.

The question of survival in the sixties will be explored by means of six symposia. They are: Survival in the Western World; The American Community Looks at Civil Defense; Fallout and New Shelter Program; Natural Disasters and Community Hospitals: Are they prepared?; National Self-Help Program and Austere Medical Care; What's New in Mass Casualty Care?

For advance registration and additional information write to Mr. Frank W. Barton, Secretary, Council on National Security, American Medical Association, 535 North Dearborn, Chicago 10, Illinois.

# Fall Postgraduate Courses Scheduled in Area of Ohio Offer Doctors Excellent Choice of Subjects

District organizations and other groups have scheduled some excellent postgraduate programs in various areas of the State during the Fall season. The September issue of *The Journal* listed a number of programs beginning on page 1040. Some of these programs were scheduled in September. Others are still in the future and deserve careful consideration by physicians in respective areas. Here are the courses announced to *The Journal* before this issue went to press:

October 5 — Association of Physicians of the Ohio Department of Mental Hygiene and Correction, Columbus State Hospital.

October 11 — Northwestern Ohio Medical Association, Findlay Country Club, Findlay (see September issue, page 1041).

October 18 - 20 — Ohio Academy of General Practice, Annual Assembly, Columbus (see article in this issue).

October 24 — Sixth Councilor District Postgraduate Day, Akron (see September issue, page 1042).

October 24 — Ohio Psychiatric Association, Cincinnati (see article this issue).

October 26 - 28 — American Heart Association, Annual Meeting and Scientific Session, Cleveland (see article this issue).

November 19 — Academy of Medicine of Columbus and Franklin County, Clinic Day Type Program, Columbus (see September issue, page 1044).

November 26 — American Society of Hematology, Annual Meeting, Columbus.

## State Medical Board Issues Licenses to 307 M.D.'s

The State Medical Board of Ohio met on August 14 and considered results of the examinations given in Columbus June 14-16. Certificates to practice Medicine and Surgery were authorized for 307 graduates of Schools of Medicine. At the same time the Board authorized certificates to 54 graduates of Osteopathic schools who are authorized to practice Osteopathic medicine and surgery. Also 14 chiropodists (podiatrists) will receive certificates.

In the limited practice fields, certificates were authorized for 13 persons to practice mechanotherapy, 18 to practice chiropractic and 16 to practice massage.

Highest grade in the examinations for Doctors of Medicine was made by Jerold B. Federman, Akron, a graduate of Ohio State University College of Medicine, with an average of 92.9 per cent.

Two men tied for next highest grade of 92.2 per cent. They are Alfred M. Kreindler, Cincinnati, and Robert E. McCammon, Akron, both graduates of the University of Cincinnati College of Medicine.

Those licensed to practice medicine and surgery included 138 graduates of the College of Medicine of Ohio State University; 78 from the University of Cincinnati College of Medicine; 35 from Western Reserve University School of Medicine; 25 from medical schools in other states and Canada; and 31 graduates of foreign medical schools.

### Birth Defects Study To Continue

A study of birth defects which began in 1959 at Children's Hospital, Columbus, will continue under a $90,000 research contract with The National Foundation. The contract was the largest of 45 research agreements, administered through the Ohio State University Research Foundation and totaling $996,126.62, which were reported in early September to the university's Board of Trustees.

### Pediatrics Chicago Meeting

The 31st Annual Meeting of the American Academy of Pediatrics will be held in the Palmer House, Chicago, October 27 - November 1. The expanded program was made necessary by development of sections of the Academy and increased interest in these sections, E. H. Christopherson, M. D., executive director, announced. Additional information may be obtained from the Academy at 1801 Hinman Ave., Evanston, Illinois.

# Support for Medical Education . . .

## Fall Drive Launched To Keep Medical Schools Solvent And Independent; Dr. Martin Heads Ohio's Committee

OHIO physicians again have an opportunity this Fall to support the Nation's medical schools by contributing to the American Medical Association Education and Research Foundation.

Dr. Robert S. Martin, Zanesville, President of the Ohio State Medical Association in 1957-1958, is chairman of the Ohio AMA-ERF Committee, which is composed of the 11 OSMA District Councilors.

Established January 1, 1962, the American Medical Association Education and Research Foundation is the result of combining two previously established foundations. The American Medical *Education* Foundation was established in 1951 for the purpose of providing financial assistance to medical schools. The American Medical *Research* Foundation, established in 1957, had as its principal aim the betterment of public health through scientific and medical research.



R. S. Martin, M. D.

Combining AMEF and AMRF established a sounder basis for future expansion and provided unified direction and control within the framework of a single foundation.

AMA-ERF has a number of specific programs. During 1962 these are being expanded and a concerted effort made to provide increased financial assistance to medical schools and to finance other projects of the Foundation, including loans to medical students.

The Foundation seeks financial support from physicians, medical societies, and the Woman's Auxiliary to medical societies, philanthropic organizations, business entities and the general public.

**As an educational, scientific organization, organized not for profit, all contributions are tax deductible under Section 501 (c) (3) of the U. S. Internal Revenue Code.**

Affairs of the Foundation are managed by the Board of Directors elected annually by and from the membership of the Board of Trustees of the American Medical Association.

Since 1951, physicians have donated more than $11,500,000 through AMEF and AMA-ERF to the cause of medical education. Money contributed to the Foundation may be designated for a specific school. Contributions not designated are divided among the country's 86 medical schools.

Deans of the schools may use Foundation grants at their discretion for special projects or expenses outside of their budgets.

American physicians and Woman's Auxiliaries contributed more than $4,700,000 to the nation's medical schools last year, $1,303,161.10 through the Foundation and $3,428,413.09 in direct contributions to medical school Alumni Funds.

The First AMEF campaign in Ohio in 1951 produced $5,735 from 152 contributions. In 1961, there were 2,072 contributors for a total of $63,177.41, an all-time high. Of this amount, the Woman's Auxiliary to the OSMA raised $28,081.51.

Last year grants to the three Ohio medical schools from the Foundation were: Ohio State University College of Medicine, $15,293.03; University of Cincinnati College of Medicine, $13,792.10 and Western Reserve University School of Medicine, $13,720.32. Contributions received directly by the three schools from their own Alumni were: OSU, $22,016.72; UC, $44,947.80 and WRU, $59,391.48.

It is the earnest hope of Dr. Martin and the members of the Ohio AMA-ERF Committee that more Ohio physicians will respond generously in this year's campaign. Last year more than half of the members of the OSMA made contributions either to the Foundation or directly to medical schools, thus making a tangible expression of their desire to keep medical schools solvent and independent.

Supplementing the Foundation's direct-mail appeals to physicians throughout the country, members of the OSMA will receive a request for contributions soon from Dr. Martin. This will be followed-up locally by the county chairmen.

Following is a list of the county chairmen for the 1962 Ohio AMA-ERF campaign.

### First District

ADAMS—Stanley H. Title, Seaman
BROWN—George P. Tyler, Jr., Ripley
BUTLER—John L. Bauer, Middletown
CLERMONT—Carl M. Sedacca, Batavia
CLINTON—Frank G. Plymire, Wilmington

HAMILTON—Carl W. Koehler, Cincinnati
HIGHLAND—Leland Dale McBride, Hillsboro
WARREN—D. Paul Ward, Pleasant Plain

### Second District

CHAMPAIGN—Arthur B. Ream, Mechanicsburg
CLARK—Lillian M. Posch, Springfield
DARKE—Jesse L. Heise, Pitsburg
GREENE—Robert D. Hendrickson, Xenia
MIAMI—William T. Wilkins, Jr., Piqua
MONTGOMERY—Charles G. Lovingood, Dayton
PREBLE—Willard C. Clark, Jr., Eaton
SHELBY—John H. Kerrigan, Sidney

### Third District

ALLEN—F. Miles Flickinger, Lima
AUGLAIZE—Herbert S. Wolfe, New Knoxville
CRAWFORD—Charles J. Griebling, Galion
HANCOCK—Thomas R. Shoupe, Findlay
HARDIN—Stephen P. Churchill, Kenton
LOGAN—Warren F. Mills, Bellefontaine
MARION—Barney M. Wisinger, Marion
MERCER—Charles P. Adkins, Coldwater
SENECA—A. S. Lupica, Tiffin
VAN WERT—Donald W. Walters, Van Wert
WYANDOT—John M. Thompson, Upper Sandusky

### Fourth District

DEFIANCE—James E. Cameron, Defiance
FULTON—Clarence F. Murbach, Archbold
HENRY—Richard L. Gilson, Napoleon
LUCAS—Frank F. Snyder, Toledo
OTTAWA—Alfred D. Miessner, Port Clinton
PAULDING—John H. Schaefer, Paulding
PUTNAM—Walter E. Martin, Columbus Grove
SANDUSKY—Edward W. Sanders, Bellevue
WILLIAMS—Russell K. Ameter, Bryan
WOOD—Richard L. Pearse, Bowling Green

### Fifth District

ASHTABULA—Carl J. Streicher, Ashtabula
CUYAHOGA—Joseph K. Doran, Cleveland
GEAUGA—Kayoshi Masuoka, Chardon
LAKE—Joseph J. Maher, Painesville

### Sixth District

COLUMBIANA—Richard J. Bonistalli, East Liverpool
MAHONING—Louis Bloomberg, Youngstown
PORTAGE—Nathan C. T. Chang, Windham
STARK—Jerry I. Newman, Canton
SUMMIT—Eunice R. Carter, Cuyahoga Falls
TRUMBULL—Densmore Thomas, Warren

### Seventh District

BELMONT—Edward V. Arbaugh, Jr., Martins Ferry
CARROLL—P. S. Whiteleather, Minerva
COSHOCTON—N. Harry Carpenter, Coshocton
HARRISON—Gerald E. Vorhies, Scio
JEFFERSON—John Y. Bevan, Steubenville
TUSCARAWAS—Samuel H. Winston, Dover

### Eighth District

ATHENS—Robert E. Main, Athens
FAIRFIELD—Galon S. Rodabaugh, Lancaster
GUERNSEY—F. Gordon Lawyer, Cambridge
LICKING—J. Fleek Miller, Newark
MORGAN—Austin A. Coulson, McConnelsville
MUSKINGUM—Donald A. Urban, Zanesville
NOBLE—Frederick M. Cox, Caldwell
WASHINGTON—W. D. Turner, Marietta

### Ninth District

GALLIA—Charles E. Holzer, Jr., Gallipolis
HOCKING—Jan S. Matthews, Logan
JACKSON—Earl J. Levine, Wellston
LAWRENCE—Franklin W. Crowe, Ironton
MEIGS—Edmund Butrimas, Pomeroy
PIKE—William W. Wiltberger, Waverly
SCIOTO—Dow Allard, Portsmouth

### Tenth District

DELAWARE—James G. Parker, Delaware
FAYETTE—James E. Rose, Washington C. H.
FRANKLIN—C. Joseph DeLor, Columbus
KNOX—John L. Baube, Mt. Vernon
MADISON—Ernest S. Crouch, London
MORROW—C. S. Jackson, Mt. Gilead
PICKAWAY—Edwin S. Shane, Circleville
ROSS—Charles N. Hoyt, Chillicothe
UNION—James W. Sampsel, Marysville

### Eleventh District

ASHLAND—H. Wayne Smith, Ashland
ERIE—Henry W. Lehrer, Sandusky
HOLMES—Clyde Bahler, Walnut Creek
HURON—John Blackwood, Jr., Norwalk
LORAIN—Frank R. Neff, Lorain
MEDINA—Rodolfo F. Fasoli, Brunswick
RICHLAND—Melvin M. Christian, Mansfield
WAYNE—F. C. Ganyard, Wooster

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## Industrial Back Injuries Subject of Seminar

"Rehabilitation of Industrial Back Injuries" will be the subject of a seminar sponsored jointly by The Ohio State University College of Medicine, Ohio Rehabilitation Center, Physical Medicine and Rehabilitation Service and the Ohio Bureau of Vocational Rehabilitation, October 26 and 27 in Columbus.

Registration opens at 8:00 a. m. on Friday, October 31, with the first program feature at 8:50 a. m. in the Ohio Rehabilitation Center, 472 West Eighth Avenue, Columbus (near King Avenue in the OSU Health Center area). Program continues on Saturday morning. Tickets are available for the OSU-Wisconsin football game on Saturday afternoon.

An outstanding faculty from Ohio State as well as from other centers will present the program.

# Buckeye News Notes . . .

**Barberton**—Dr. James G. Roberts, chairman of the public relations committee of the Summit County Medical Society discussed "Socialized Medicine" before a recent meeting of the Barberton Rotary Club.

**Canton**—A panel of physicians representing the Academy of Medicine of Canton recently presented a program for the registered nurses of District 1 of the Ohio State Nurses' Association. Drs. William White, Robert Tschantz and Maurice Lieber spoke on the problems involved in medical care for older persons, with particular reference to the King-Anderson Bill.—*Canton Repository.*

**Canton**—Director of the Ohio Department of Health, Dr. Ralph E. Dwork, delivered the commencement address at the 68th annual graduation exercises of the Aultman Hospital School of Nursing. Dr. Dwork spoke on "The Nurse as a Citizen."

**Cincinnati**—Dr. and Mrs. Joseph E. Ghory attended the International Congress of Pediatrics in Lisbon in early September. Dr. Ghory read a paper on "Allergy."

**Cincinnati**—When the "Flying Physicians," a group of doctors who fly their own planes, met at Jeckyl Island, Georgia, recently, Cincinnati was represented by Dr. Henry C. Beekley.

**Cleveland**—Two Clevelanders flew from New York to South America recently where the hospital ship SS Hope continues its medical teaching mission in Peru. They are Dr. Bernard S. Abrams and Dr. Nick Sperelakis.

**Columbus**—Dr. William S. Reed, of Henderson, Texas, spoke on "The Spiritual Aspect of Medical and Surgical Practice—Toward a Christian Discipline in Surgery" before a recent luncheon meeting of the Mercy Hospital medical staff.

**East Liverpool**—Dr. John A. Fraser told the East Liverpool Lions Club recently that, "The doctors are making the fight against the socialistic trend of government (against H.R. 4222) for you as much as for themselves." Dr. Fraser is a long-time member of the legislative committee of the Ohio State Medical Association. He told the club that the plan to control the nation's doctors "is a further step toward socialization."

**Lancaster**—The medical staff of Lancaster — Fairfield County Hospital recently passed unanimously, at a regular meeting, a motion that the staff is opposed unalterably to the King-Anderson Bill.—*Lancaster Eagle-Gazette.*

**Marietta**—Eight acres of land has been chosen as the site for the new Selby General Hospital in Marietta. Workers in the building fund drive have to date raised approximately 60 per cent of the campaign goal of $250,000 which is needed to construct the 50-bed facility.

**Salem**—Dr. Jack Schreiber of Canfield spoke regarding the Kerr-Mills and King-Anderson medicare bills under consideration by members of Congress at a recent meeting of the Republican Women's Club of Salem.—*The Salem News.*

**Sandusky**—Dr. Frederick M. Wilkins was the guest speaker at a recent meeting of the North Central Crime Clinic held in Sandusky. Dr. Wilkins, chairman of the department of radiology and nuclear medicine at Sandusky Memorial Hospital, discussed "Understanding Radioactivity."—*Sandusky Register.*

**Toledo**—Dr. Robert A. Chapman, formerly of Toledo, his wife and two children, are living in Ethiopia where Dr. Chapman is connected with the Sudan Interior Mission. Dr. Chapman serves as physician to the Shashamane Leprosarium.

**Uhrichsville**—Dr. Jay W. Calhoon spoke on the American Medical Association and its opposition to H. R. 4222 at a recent meeting of the Buckeye Club. —*Uhrichsville Evening Chronicle.*

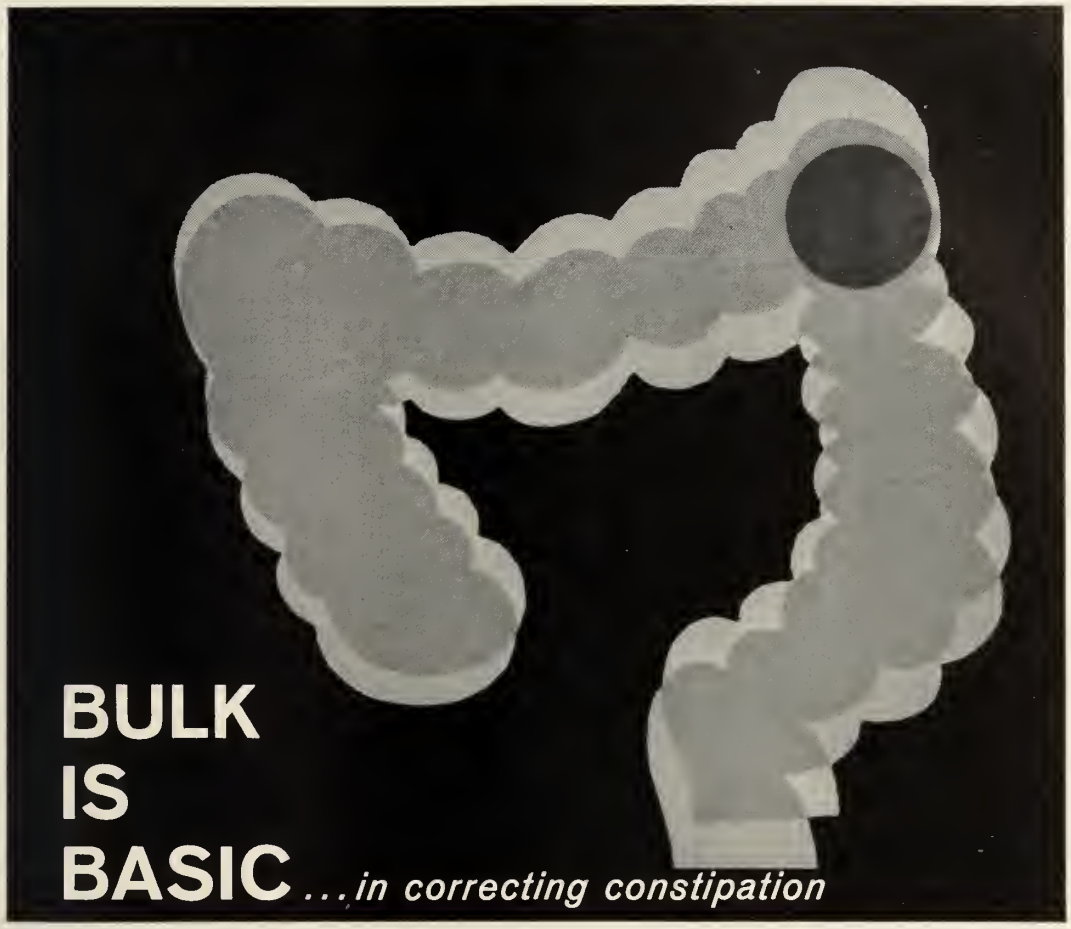
**Washington C. H.**—Dr. Byers Shaw was the guest speaker at the Washington C. H. Business and Professional Women's Club held recently. Dr. Shaw spoke on the AMA's views concerning the King-Anderson Bill.—*The Springfield Sun.*

**Wellington**—Dr. DeWitt E. Harrison, Elyria, spoke before a recent meeting of the Southern Lorain County Hospital Auxiliary. Dr. Harrison discussed the topic "Cancer in Women."

**Youngstown**—Dr. Arthur E. Rappoport, pathologist of the Youngstown Hospital Association, was the program chairman for the College of American Pathologists' joint meeting with the American Society of Clinical Pathologists, held in early September in Chicago.

**Youngstown**—"Health Care for the Aged" was discussed by Dr. G. W. Stertzbach and Dr. Jack Schreiber at a meeting of the Ohio State Nurses of District No. 3.—*Youngstown Vindicator.*

**Youngstown**—Dr. Henry Shorr, speaking at a recent meeting of the North Side Kiwanis Club, advocated a medical care program for the aged on a voluntary basis. Dr. Shorr opposed the administration sponsored King-Anderson Bill to provide medical care for our elderly citizens through Social Security.—*Youngstown Vindicator.*




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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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*Research in the Service of Medicine*

## Ohioans Featured in American Heart Association Program

Ohio physicians will play eminent roles in the program of the annual American Heart Association meeting and 35th scientific sessions at Cleveland Public Auditorium Friday - Sunday, October 26-28.

Of particular interest will be a symposium on "Appraisal of Open Heart Surgery for Acquired Valvular Disease" Saturday morning, October 27, co-sponsored by the Council on Cardiovascular Surgery. George A. Clowes, Jr., M. D., formerly of Cleveland, will speak on "Mitral Disease," while Doctors Earle B. Kay, David Mendelsohn, Jr., and Henry A. Zimmerman, Cleveland, will present an analysis of "The First 100 Patients in Aortic Valvular Surgery with Artificial Valves." Twenty-four additional physicians will participate in the symposium on heart surgery.

Also scheduled Saturday morning is an Intercouncil Session on Electrocardiography in which Doctors James McB. Garvey, Jr., David T. Rowlands, and Ralph C. Scott, Cincinnati, will discuss "The Relation of Left Ventricular Weight to the Electrocardiographic Diagnosis of Left Ventricular Hypertrophy." Ten additional presentations will be made.

A symposium Friday afternoon on "Medical Management of Hypertension," held jointly with the Council for High Blood Pressure Research, will feature Doctors Philip A. Khairallah, F. Merlin Bumpus, Irvine H. Page, and Robert M. Smeby, Cleveland, in a discussion on "Tritiated Angiotensin." Harriet P. Dustan, M. D., Cleveland, will present a paper on "To Treat or Not to Treat." Other subjects covered in this session will be "Etiology and Natural History," "Diagnostic Tests," "Use and Abuse of Drugs," "Value of Alpha-methyl-dopa" and "Hydrochlorothiazide in Hypertension."

Among the Friday morning opening sessions will be "Coronary Heart Disease in an Industrial Population, A Prospective Study," by Wesley Dupertuis, M. D., Cleveland, and a team of Chicago physicians: Oglesby Paul, Mark H. Lepper, Adrian Ostfeld, Anne MacMillan, and William H. Phelan. The program will be co-sponsored by the Council on Arteriosclerosis.

Saturday evening's series of cardiovascular conferences, to be held at the Sheraton-Cleveland Hotel, will consist of 20 sessions in which ten Ohio physicians will figure. They are James V. Warren, Columbus, "Venous Mechanisms Influencing Cardiac Output and Blood Pressure;" and the following physicians from Cleveland:

Earle B. Kay, "Artificial Heart Valves"; George A. Clowes, Jr., "Problems of Extracorporeal Circulation"; F. Mason Sones, Jr., "Cineangiocardiography"; Herman K. Hellerstein, "Environment and Atherosclerosis"; A. Carlton Ernstene, "Congestive Heart Failure."

Also, Harriet P. Dustan, "Newer Antihypertensive Drugs"; Oscar D. Ratnoff, "Potential Use of Fibrinolysis"; Harold Feil, "Management of Patients with Angina Pectoris," and Walter J. Pritchard, "Clinical Pathological Conference."

Dr. Warren, who is president-elect of the American Heart Association, will chair the final session on Clinical Cardiology Sunday afternoon. Covered will be "Frequently Unrecognized Forms of Heart Disease"; "Pathology of Carcinoid Heart Disease"; "Presystolic Gallop"; Hemodynamics and Lung Function in Hypertensive Pulmonary Vascular Disease"; and "Critical Review of Advances in Cardiology."

Interested physicians, medical students, scientists, and laymen are invited to attend the American Heart Association annual meeting. Registration and housing forms may be secured from any local Heart chapter or from the Ohio State Heart Assn., 131 E. State St., Columbus 15.

Host associations for the annual meeting are the Ohio State Heart Association and the Cleveland Area Heart Society.

## Registration Now Open for AMA Clinical Meeting

Current issues of *The Journal of the AMA* are carrying advance registration blanks and coupons for room reservations for the Clinical Meeting of the American Medical Association in Los Angeles, California, November 25 - 28.

Advance registration form must be in the hands of the Circulation and Records Department of the AMA before November 12.

Completed room reservation forms should be sent as early as possible to the Los Angeles Convention Bureau. (See *Journal of the AMA* for coupon.)

Many Ohio physicians are planning to attend the Clinical Meeting, which promises an excellent scientific program. An early issue of the *JAMA* will carry the program with other interesting data on the session.

## Writing Fellowship Grant Is Offered in 1963

To mark its 75th anniversary in 1963, the W. B. Saunders Company, medical and scientific publishers, are making available $15,000 for an unusual medical writing award.

The purpose of the grant is to provide a year's leave of absence for a distinguished investigator who: (1) has been doing important biomedical laboratory research; and (2) would like to have time for preparation of his work in monographic form.

Details may be obtained from Dr. Robert F. Loeb, W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa.

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## Anderson and Javits Introduce New Medicare Bill

A bill has been introduced by U. S. Senators Anderson and Javits which is expected to be the basic Social Security health care proposal in the next Congress. Known as S. 3565, it contains these basic features:

### Eligibility

Covers all over 65 for the following:

### Benefits

Up to 90 days of "inpatient hospitalization" subject to a deductible of $10 for each of the first 9 days of hospitalization with a minimum deductible of $20; up to 180 days of "skilled nursing facility services" but the combined inpatient hospital services and skilled nursing facility services would not exceed 150 units of services furnished during a "benefit period." (A unit of service would be equal to 1 day of inpatient hospital services or 2 days of nursing facility services); "home health services" up to a maximum of 240 visits during a calendar year; "outpatient diagnostic services" during the first 30 days of a benefit period subject to a deductible of $20; and drugs and biologicals.

### Payment for Services

Payment for services would be based on the "reasonable cost" of services. The Secretary of HEW would prescribe, in regulation, methods for determining the cost.

### Option To Use Private Insurance

Any individual entitled to payments under the bill would be given the election to have payments for authorized services made to an eligible insurance carrier under an approved plan, instead of for payment made directly to the providers of services.

### Financing

The program would be financed by increasing the social security tax and the tax base. Benefits for those not covered by social security would be paid out of general revenues.

## Paramedical Groups Planning National Organization

Authority for the following is the August 6 issue of *Washington Report on the Medical Sciences:*

"Soon there will be a Congress of Allied Health Sciences. Composed of professionals in fields allied to medical practice, CAHS may prove to be a potent force not only in reshaping clinical customs and procedures but in influencing national legislation. It is still in throes of organization and incorporation, hence it is still too early to say how big it will be and which professions it will represent. But backers say the Congress will start out with more than 200,000 affiliated members in all 50 states.

"Last year AMA acknowledged increasing importance of paramedicals in the clinical picture when it set up a Commission to Coordinate the Relationships of Medicine with Allied Health Professions and Services. Jurisdictional jams involving psychiatrists and psychologists, pathologists and laboratory technicians, ophthalmologists and optometrists continue to mount. Establishment of this new group may facilitate amicable coordination of professional services — or pose a new obstacle."

## Celebrezze Praises NMA For Supporting Medicare

Secretary of HEW Anthony J. Celebrezze wired congratulations to the National Medical Association for its convention resolution supporting the principle of furnishing health services to the aged under Social Security. Its action, he told NMA President John A. Kenny, of the Howard University faculty, "gives new strength and inspiration to our efforts to make certain that Americans 65 and over will be able to meet hospital costs and essential health care services."

Heretofore there has been a cleavage in the ranks of the Negro medical group over medical eldercare, with forces opposed to the Social Security approach having a slight edge. However, at its 67th annual meeting in Chicago, the favorable resolution was carried 106 to 71.


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# Ad Astra

**Bernard Phillip Bresin,** M. D., Cleveland; Ohio State University College of Medicine, 1936; aged 51; died September 4; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology. A native of Cleveland, Dr. Bresin served most of his professional career there, with time out for military duty in the Coast Guard Medical Corps during World War II. A member of the Park Synagogue, he is survived by his widow, a son, a daughter, two brothers and a sister.

**Edward Morris Brickman,** M. D., Warrensville; University of Michigan School of Medicine, 1927; aged 59; died September 4; member of the Ohio State Medical Association, the American Medical Association and the International College of Surgeons. Dr. Brickman was a practicing physician in Warrensville for about 30 years and a veteran of World War II, during which he served in the Army Medical Corps. Affiliations included membership in the Masonic Lodge and activity in Jewish welfare projects. Survivors include his widow, three sons, two stepdaughters and a brother.

**Clayton Thomas J. Dodge,** M. D., Cleveland; Western Reserve University School of Medicine, 1920; aged 72; died August 14; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A native of Cleveland, Dr. Dodge served all of his professional career there, specializing in pediatrics. Among affiliations he was a member of the Methodist Church and belonged to the Sons of the American Revolution. Surviving are his widow, a son, a daughter and a sister.

**Orr Falls,** M. D., East Cleveland; Western Reserve University School of Medicine, 1920; aged 69; died August 23; former member of the Ohio State Medical Association. A practicing physician in the Greater Cleveland area for some 42 years, Dr. Falls was health director for the East Cleveland public schools. Among affiliations he was a member of the Kiwanis Club and was a veteran of the World War I Medical Corps. Survivors include his widow, two daughters, a sister and a brother.

**James Joseph Fay,** M. D., Cincinnati; Eclectic Medical College, 1925; aged 62; died August 20; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Dermatology and Syphilology. A practicing physician for many years in Cincinnati, Dr. Fay was a veteran of both World Wars, having served in the Medical Corps during World War II. Among affiliations he was a member of the Xavier Boosters Club. Surviving are his widow, Dr. Martha V. Fay, also a Cincinnati physician; two daughters and a brother.

**Stanley S. Gardner,** M. D., Ft. Pierce, Fla.; University of Michigan Medical School, 1916; aged 69; died July 16. A former practicing physician in the Cleveland area, Dr. Gardner had been living in Florida since retirement.

**Amin Y. Karim,** M. D., Cleveland; Cleveland-Pulte Medical College, 1914; aged 75; died August 23. A native of Lebanon, Dr. Karim came to this country in 1905 and practiced for many years in Cleveland. He retired in 1954. Surviving are his widow, two sons, a sister and a brother.

**Jean Bertram Ruhl Koupal,** M. D., Toledo; Columbia University College of Physicians and Surgeons, 1926; aged 61; died August 25; member of the Ohio State Medical Association; member of the American Diabetes Association and the American Psychiatric Association. A former practicing physician in New York City, Dr. Koupal moved to Toledo in 1943. She was associated with the local health department before going into private practice. A member of the Order of the Eastern Star and DAR, she is survived by her husband, T. Morse Koupal, a son, four sisters and a brother.

**Ernest George Kuhlman,** M. D., East Liverpool; University of Pennsylvania School of Medicine, 1915; aged 79; died July 30; member of the Ohio State Medical Association. Dr. Kuhlman's practice extended over 47 years. He had been in East Liverpool since 1941 and for about 10 years was city health commissioner. Surviving are his widow, a son and a brother.

**John David Latta,** M. D., Lima; Ohio State University College of Medicine, 1936; aged 51; died August 21. A career psychiatrist, Dr. Latta served on the staffs of several state hospitals, including the Lima State Hospital. He resigned his post there in 1961 for health reasons. A member of the Baptist Church and the Elks Lodge, he is survived by his widow, a son, a daughter and three sisters.

**William Frank Maxwell,** M. D., Toledo; University of Michigan Homeopathic Medical School, 1905; aged 87; died August 16; member of the Ohio State

Medical Association and the American Medical Association. After three years on the staff of the Michigan State Hospital in Ionia, Dr. Maxwell moved to Toledo where he remained in practice until his retirement in October of last year. He served in the Medical Corps during World War I and was for two years at the Base Hospital in Carlisle, Pa., where he headed the Department of Psychiatry. Later he did graduate work in psychiatry. During World War II he served as medical director of Civil Defense. A member of the Masonic Lodge, he is survived by his widow, a son and a brother.

**William Joseph Pittenger,** M. D., Cuyahoga Falls; St. Louis University School of Medicine, 1931; aged 59; died September 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Pittenger lived virtually all of his life in the Summit County area, his family having moved to Akron when he was a baby. He practiced for some 31 years in Summit County and for the last 10 years was county coroner. He was a member of the Ohio State Coroners' Association. Among affiliations was his membership in the Catholic Church and the Knights of Columbus. Survivors include his widow, four daughters, his mother, two sisters and two brothers.

**Horace Lyman Prouty,** M. D., West Liberty; Cleveland University of Medicine and Surgery, 1897; aged 87; died August 12; former member of the Ohio State Medical Association and the American Medical Association. Dr. Prouty opened his practice in West Liberty upon completion of his medical training and served virtually all of his professional career there. During World War I he served in the Medical Corps. Active in local affairs, he was long a member of the local School Board and was a member of the Presbyterian Church. Survivors include two sons, a daughter and a brother.

**Jerold Mark Rosenblum,** M. D., Cleveland; Ohio State University College of Medicine, 1949; aged 36; died September 1; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology; former faculty member at Western Reserve University School of Medicine. Dr. Rosenblum was a native of Youngstown and had been practicing in Cleveland for eight years. Surviving are his widow and three children; also a brother.

**John Geoffrey Snavely,** M. D., Toledo; Yale University School of Medicine, 1941; aged 46; died August 5; member of the Ohio State Medical Association, American Medical Association, College of American Pathologists and the American Society of Clinical Pathologists; diplomate of the American Board of Pathology. A native Ohioan, Dr. Snavely took his internship in Cleveland, then practiced in Connecticut for a while before moving to Toledo in 1952 to continue his practice in pathology. Surviving are his widow, a daughter, a step-daughter, two sons, his step-mother, a brother and a step-brother.

**Wilbur Abia Taylor, Sr.,** M. D., Toledo; Chicago College of Medicine and Surgery, 1914; aged 72; died August 10; member of the Ohio State Medical Association and the American Medical Association. Dr. Taylor practiced for some 45 years in Toledo, moving there shortly after completion of his medical training. Among affiliations he was a member of the Congregational Church and several Masonic bodies. Survivors include two sons, Dr. Robert Taylor, and Dr. Wilbur Taylor, Jr., both of Toledo.

**Allison Kaye Walker,** M. D., Little Hocking; Starling Medical College, Columbus, 1902; aged 90; died August 17 at the home of his daughter in Columbus; former member of the Ohio State Medical Association. Dr. Walker practiced for many years in the Athens County area around Buchtel. He later made his home in Little Hocking, Washington County.

**Willis Edward Wygant,** M. D., Mansfield; University of Cincinnati College of Medicine, 1919; aged 69; died August 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Wygant's practice in Mansfield began in 1920. He was active in the Richland County Medical Society and formerly served as its president. Other activities included membership in the Baptist Church and the Rotary Club. Surviving are his widow, a son, a brother and a sister.


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# Do You Know?...

Cincinnati's Deaconess Hospital recently received a check for $250,000 from Louis Nippert, nephew of the late Miss Olivia P. Gamble and executor of her estate.

* * *

Eight institutions, seven of them in the Akron area, are the beneficiaries of a total of $67,500 in the latest distribution of Sisler-McFawn Foundation funds. The Foundation, established in the will of the late Mrs. Lois Sisler McFawn, is one of the largest community trusts in the country.

* * *

Dr. J. A. Agnew, Crestline, has retired as a member of the Crawford County board of health. Dr. Agnew, who recently retired from active practice, had served on the board since 1920.

* * *

Dr. Kenneth W. Clement, of Cleveland, was chosen recently as president-elect of the National Medical Association at their 67th annual convention in Chicago. The NMA is the primary Negro medical association in the U.S.

* * *

Dr. Charles V. Bowen Jr. of Cuyahoga Falls, has been elected president of the Akron Obstetrical and Gynecological Society. Dr. Bowen will be assisted in office by Dr. L. M. Walker, president-elect and Dr. George D. Solomon Jr., secretary-treasurer.

* * *

One of medicine's oldest mysteries, shock, will be studied in a five-year research project at St. Vincent Charity Hospital, Cleveland. A grant of $139,000 from the U.S. Department of Health, Education and Welfare is financing the project.

Dr. James L. Goddard, formerly of Kalida, Ohio, has become assistant surgeon general in charge of the communicable disease of the U.S. Public Health Service. Dr. Goddard has been civil air surgeon of the Federal Aviation Agency since 1959 under loan from the Public Health Service.

* * *

A grant of $241,500 for a seven-year study of artificial heart valves has been awarded to Dr. Earle B. Kay of St. Vincent Charity Hospital, Cleveland. The grant from the National Heart Institute of the U.S. Public Health Service, is one of the largest grants ever given in the Cleveland area for an individual heart project.

* * *

Dr. Robert J. Adolph has been named assistant professor of internal medicine at the University of Cincinnati School of Medicine. Dr. Adolph will teach and continue heart research in the UC Medical Center's cardiac laboratory.

* * *

Dr. Richard Katz of Canton has been appointed teaching fellow in pediatrics at the Harvard Medical School and its affiliated hospitals. Dr. Katz has been associated with Canton's Children's Hospital Medical Center.

* * *

Florence Alexander, R. N., Ph. D., will become director of the AMA's Dept. of Nursing and secretary of its Committee on Nursing in September. She succeeds Veronica L. Conley, R. N., Ph. D., the department director since 1960, who resigned to become executive director of the National Association of




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MEMBER: *American Hospital Association — National Association of Private Psychiatric Hospitals*

Practical Nurse Education and Service. Dr. Alexander formerly served as consultant in nursing service at the Syracuse, N. Y., Memorial Hospital.

* * *

Dr. John S. Wisely has been named Portage County health commissioner by the Board of Health. Dr. Wisely was formerly associated with public health work in Michigan.

* * *

Two greater Clevelanders, Dr. Norton J. Greenberger and Dr. Gary D. Friedman, have received appointments to the Harvard Medical School and its affiliated hospitals. Dr. Greenberger has been named a research fellow in medicine. Dr. Friedman has been appointed a research fellow in preventive medicine.

* * *

Dr. J. Paul Sauvageot, Akron, has been appointed director of medical education at St. Thomas Hospital. St. Thomas is the first Akron area hospital to have a director of medical education on a full time basis. Dr. Sauvageot has held the post under a part-time arrangement since January.

* * *

Dr. Reich L. Watterson Jr., director of the department of physical medicine and rehabilitation at Mercy and Timken Mercy hospitals, was named recently to the five-member City Health Board by Canton Mayor James H. Lawhun.

* * *

A $10,580 grant from the National Institutes of Health will continue research in diagnosis of toxoplasmosis at Ohio State University. The grant will support work being conducted by Dr. Clarence R. Cole, chairman of the department of veterinary pathology. Dr. Cole is trying to determine the importance of animals as reservoirs for human toxoplasmosis, a disease which causes blindness and brain damage in children.

## Medicolegal Symposium Planned In Florida by AMA

Plans are now being made for a Medicolegal Symposium to be held at the American Hotel in Miami Beach, Florida, on Friday and Saturday, March 8-9, 1963. All interested physicians are invited by the American Medical Association to attend this symposium.

The AMA, since 1955, has conducted three meetings of this type every two years in different sections of the country. All of the previous twelve meetings have been successful from the standpoint of program, attendance and enthusiasm.

This year, the AMA decided to schedule one meeting instead of three separate meetings and hopes to have an attendance of from 850 to 1,000 persons, as evenly divided as possible between physicians and attorneys.

## University of Toledo Aims At 1966 Medical School

The University of Toledo hopes to have a medical school operating by the autumn of 1966. This is reported by the public press throughout Ohio.

The primary step in a four-year development program announced in mid-July is the seeking of $1.8 million for preliminary planning. It is hoped that private, non-profit foundations will provide the funds.

The development program was made public by trustees of the Toledo Area Medical College and Education Foundation, a group that includes Dr. William S. Carlson, University president.

A three-man team of medical educators, who toured the state earlier this year seeking sites for new medical schools, recommended that the state legislature appropriate $1 million for development of a medical school in Toledo.

Tentative plans call for a $10 million basic science building and a $15 million teaching hospital to be built on a 45-acre site at the university.

Trustees anticipate the federal government will provide up to two-thirds of the construction costs under legislation pending in Congress. The remaining one-third would come from state funds, trustees noted.


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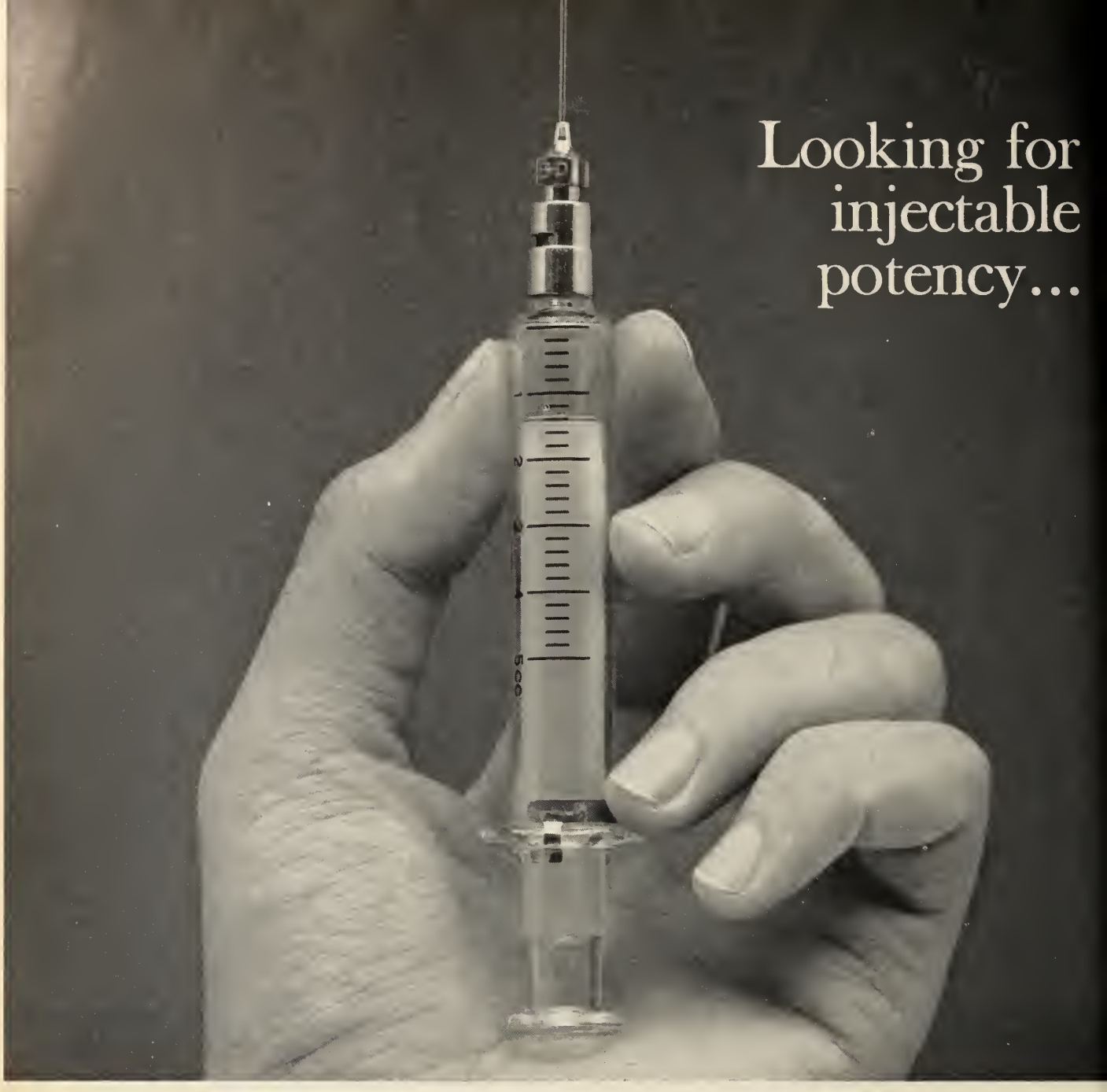
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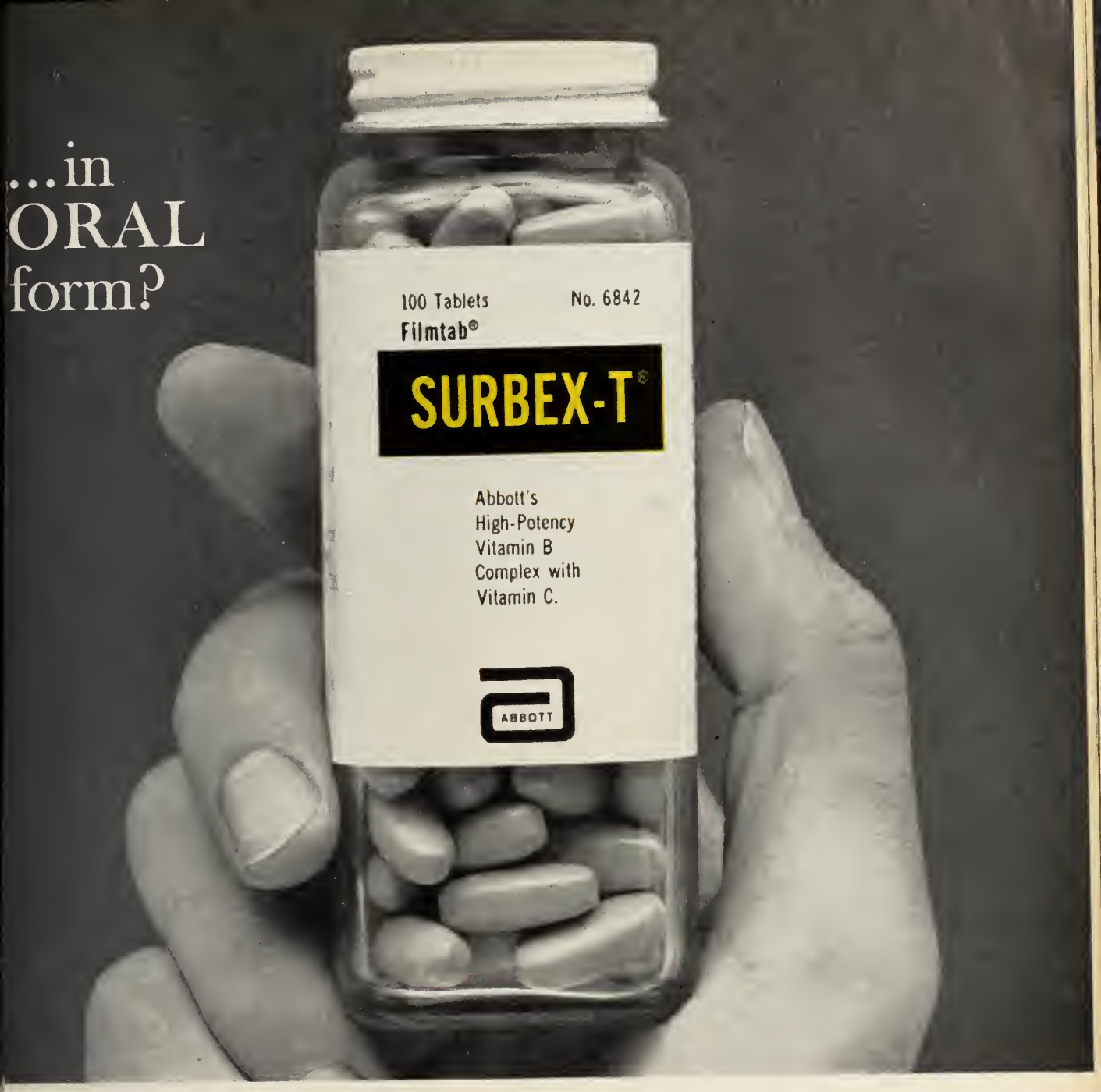
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## Curtis Bill Passes House Ways And Means Committee

The House Ways and Means Committee has approved a bill (H. R. 10117) which would provide a tax incentive for employers to provide health care in employee retirement programs. The bill had been introduced on February 7 by Rep. Thomas B. Curtis (R., Mo.) as an alternative to H. R. 4222. Action by the House Committee on the Curtis bill at this time came as a surprise. The bill has a chance for enactment, even though it is late in the session. The unanimous vote in the Ways and Means Committee indicates there is general support for the measure. The AMA Board of Trustees, following a recommendation of the Council on Legislative Activities, gave approval to the bill at its April meeting.

### Curtis Comments

Curtis explained that the individual would be able to provide for financing his future health needs by payment, through fringe benefits, on health insurance during his working years. The Missouri Congressman declared that passage of his bill would take much of the steam out of the Administration's drive for health care financed under the Social Security mechanism.

### How It Would Work

The Curtis bill would allow a tax deduction on company payments to medical funds to cover the health expense of retired employees. Curtis explained that because of the severe tax penalty involved, industry has consciously avoided adding medical expenses to retirement programs. He said 15 million workers are now covered by pension funds containing about $50 billion. If medical aid could be provided to these workers and their wives upon retirement, he continued, it would go a long way toward meeting the aged health care needs. As passed by the Committee, the bill would permit medical benefits for the retiree, plus his spouse and dependents.

## 11 Hospitals in Two-Way Hookup With OSU Medical Programs

An educational grant-in-aid of $6,000 has been presented to the Ohio State University College of Medicine by the Warren-Teed Products Co., Columbus, to support the college's new two-way radio educational network to be put into operation this fall.

Dr. John A. Prior, assistant dean and director of the college's Center for Postgraduate Medical Education, said the grant will be used to bring postgraduate training directly from Ohio State's campus to 11 hospitals in the Dayton and central Ohio areas.

The grant was presented to Dean Richard L. Meiling of the College of Medicine by Robert Workman, president of Warren-Teed, and John Warren, vice president.

Under the new program, one hour programs will be broadcast by WOSU-FM radio at Ohio State and by WHIO-FM radio in Dayton into the 11 community hospitals, including Chillicothe General Hospital, Fairfield General Hospital, Lancaster; Marion General Hospital; Mercy and Springfield City Hospitals; Mercy Memorial Hospital, Urbana; and Good Samaritan, Miami Valley, St. Elizabeth, and Wright-Patterson AFB Hospitals, Dayton.

In each broadcast two Ohio State faculty members will discuss related aspects of a certain medical subject for about 25 minutes. The remaining time will be devoted to questions originating in the hospitals.

The network has been set up so that physicians meeting in each of the participating hospitals will hear all the questions and answers. Every talk will be accompanied by color slides and duplicate sets will be shown in each hospital during the program.

The first broadcast is scheduled for October 17. It will be followed by 12 more programs running through April 10, 1963.

---

Economic loss due to injuries last year amounted to $4.1 billion in wages and $1 billion in medical expenses, according to the National Safety Council.


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## Springfield Rotarians Hear Medicine's Story

When August was designated "Physicians Month" by the Springfield Rotary Club, physician members took advantage of the opportunity to tell medicine's story to club members.

The program committee for the month consisted entirely of physicians—Dr. D. J. Parsons, chairman, John A. Davidson, Francis C. Link and Louis H. Mendelson.

Speaker for the first weekly meeting in August was Mr. Glenn Lane, of Smith, Kline and French, who spoke on progress in the development and manufacturing of drugs and treatment of diseases.

Second speaker for the month was Dr. Lester W. Sontag, director of the Fels Institute, Yellow Springs. Dr. Sontag spoke on the purpose of the institute and its work in long range psychiatric and psychological measurements.

Dr. R. Dean Dooley, director of professional relations, Ohio Medical Indemnity, was the third speaker, and discussed voluntary and private health insurance as compared with national health insurance.

Final speaker for "Physicians Month" was Mr. Charles W. Edgar, OSMA administrative assistant, who spoke on "Government Medicine: The Other Side of the Picture." He pointed out the shortcomings of government medicine in other countries, the shortcomings and loopholes in the King-Anderson Bill, the threatened invasion of government into the personal affairs of the individual, and the destruction of the physician-patient relationship that results from government medicine.

Dr. Parsons said the programs were "very well received by our Rotary Club, which has 150 members, and I think it would be a great idea if all services clubs could have similar talks."

# New Members . . .

The following are the names of the new members of The Ohio State Medical Association since August 1, 1962. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Cuyahoga**

Richard M. Whittington, Cleveland

**Franklin**

Jerome Burman, Columbus
Frederick W. Elder, Jr., Columbus
Howard J. Fleming, Columbus
James Joseph Leonard, Columbus
Michael Meftah, Columbus
Thomas L. Meyer, Jr., Columbus
John E. Myers, Columbus
Helmut H. M. Schories, Columbus
Robert W. Sorgen, Columbus
Nick J. Teteris, Columbus

**Hamilton**

Patricia M. Doyle, Cincinnati
Richard H. Evans, Cincinnati
Robert J. A. Schurdak, Cincinnati
Walter W. Timperman, Cincinnati
Donald E. Walker, Cincinnati
Thomas L. Wright, Cincinnati

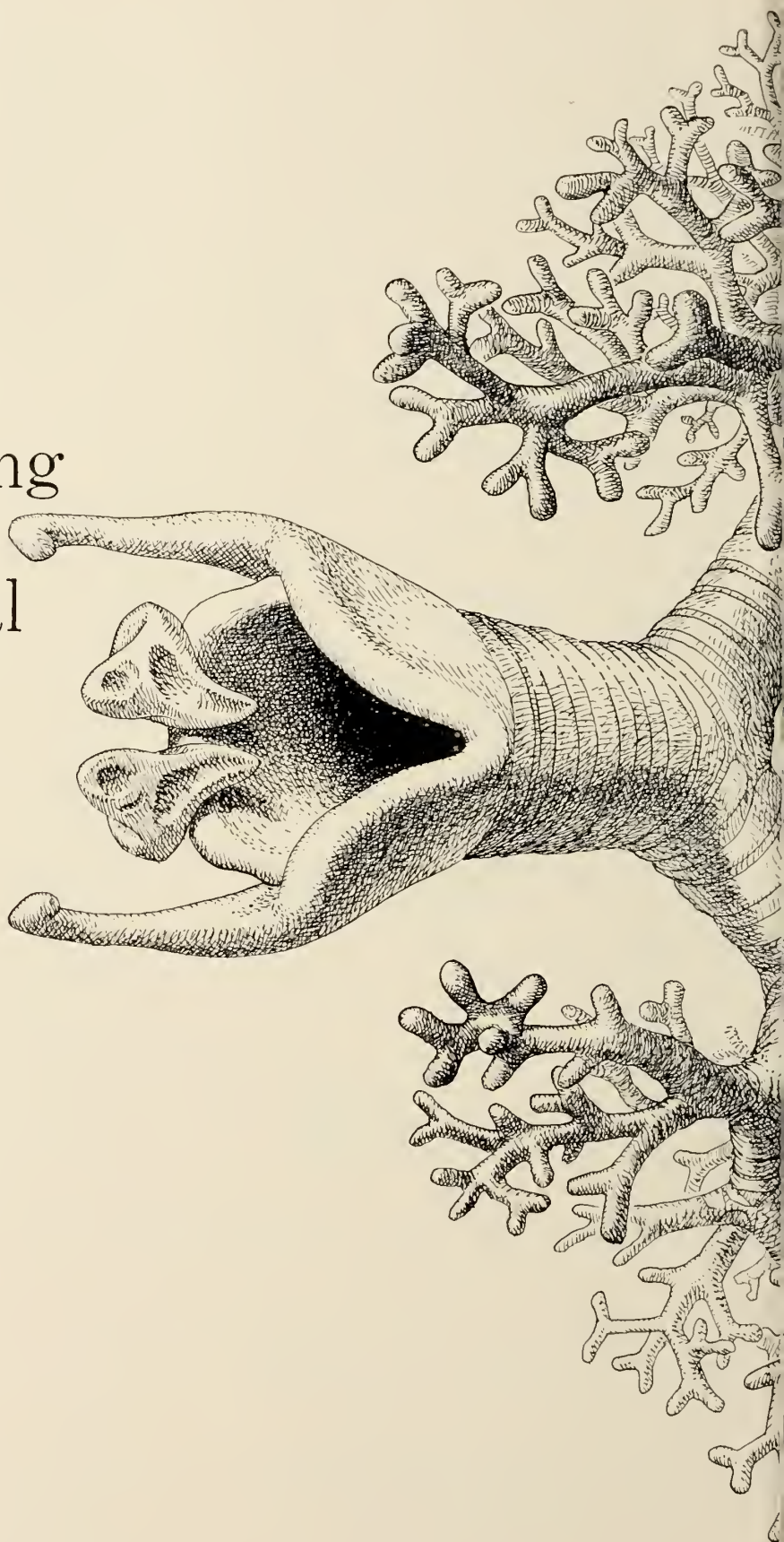
**Holmes**

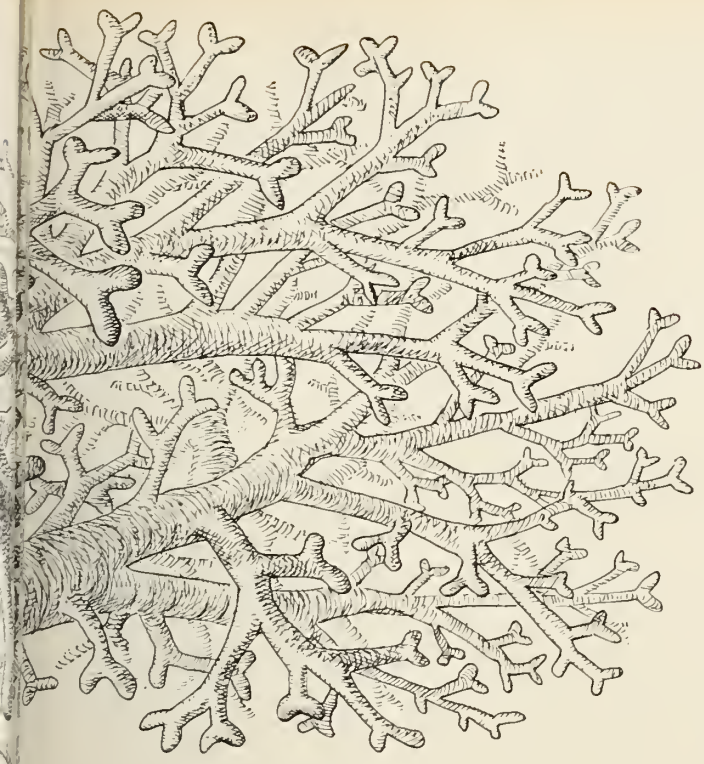
William A. Powell, Millersburg
Paul E. Roth, Killbuck

**Lucas**

Mario Stefanini, Toledo
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# HEW Releases 1961 Indicators...

## Health, Medical and Population Figures Included In Annual Wrap-Up Report from Nation's Capital

HOW many people in the United States sustained an injury last year? What is the cost of medical care? What are we doing in the area of vocational rehabilitation? These are only a few of the questions answered in a recent issue of *Indicators,* monthly publication of the U. S. Department of Health, Education, and Welfare. This article wraps-up some of the statistical highlights of 1961, based on the survey made by *Indicators.*

### Population and Vital Statistics

At year's end the **population** of the 50 states and the District of Columbia was about 185.2 million, an increase of nearly 3 million during 1961. **Births** exceeded 4.3 million for the first time. **Marriages** again totaled some 1.5 million.

There were about 1.7 million **deaths** — somewhat below the number in 1960. The **infant death rate** may again have reached a new low— below 26 deaths per 1,000 live births.

### Radioactive Fallout

Although Soviet nuclear testing in the atmosphere was resumed at the beginning of September, fallout of radioactive materials by the end of the year had not reached levels warranting undue public concern. Higher levels of fallout are expected, however.

### Health Conditions

During the year ending June 30, 1961, the rate of **acute conditions** in the civilian noninstitutional population was 201.9 conditions per 100 persons, with respiratory conditions representing about 55 per cent of all acute conditions.

Approximately 27 persons of every 100 sustained an **injury** which required medical attention or at least 1 day of restricted activity. About 43 per cent of those injured suffered home accidents.

Persons had an average 5.8 days of **bed disability** due to illness, impairments or injuries. Employed persons lost an average of 5.4 days from work, and school children between the ages of 6 and 17 lost 4.8 days from school.

About 13.5 million persons, exclusive of those in institutions, have **chronic activity limitation** affecting their major activity — the ability to work, keep house, or go to school. Of these about 42 per cent have had their limitation for 5 years or more; 37 per cent, from 1 to 5 years; and 16 per cent for less than 1 year. The remaining 5 per cent fall into the unknown category.

### Mental Health

The estimated average number of **resident patients in State and local Government mental hospitals** in the United States during 1961 was 524,100, or 1.7 per cent below the average of 533,400 in 1960. These figures resulted from a net increase in admissions of 5.2 per cent and a decline of 5.8 per cent in releases.

### Paralytic Polio

There were about 850 **paralytic polio** cases in 1961, the best year recorded since at least 1920. No geographic concentrations of cases were noted. Ninety-eight million people, 62 per cent of the population under 60 years of age, have had at least one dose of polio vaccine. About 32 per cent have had four or more doses, as compared to 25 per cent in 1960. As of September, 1961, only 8.6 million of the preschool children (where incidence of polio is highest) were inadequately protected (less than three injections, with 4.1 million of these having had no vaccine. About 49 per cent of persons 20 to 40 years old are now fully vaccinated.

### Home Care

Approximately **1,128,000 persons, or 616 per 1,000 in the noninstitutional population, received either constant care or part-time help in their homes.** Among persons 75 years and over the proportion receiving care was 87.7 per 1,000 population, with about 60 per cent of these persons requiring constant care.

### Health Insurance

National Health Survey findings show that **68 per cent of the persons discharged from short-stay hospitals have some part of their hospital bill paid by insurance.** The percentage paid by insurance increases in accordance with amount of family income, with 40 per cent paid for persons in families with income less than $2,000 and 81 per cent for those with family incomes of $7,000 or more.

### Medical Care Prices

The **medical care** component of the consumer price index rose more than 3 per cent during the year, as compared with about 1 per cent for the overall

index. Although virtually all elements of medical care prices rose, the greatest upward pressure resulted from increases in hospital room rate and the closely related hospitalization insurance premiums.

### Water Resources and Pollution Control

**Contract awards for municipal sewage treatment works** totaled about $430 million during 1961 — an increase of $40 million over record 1958. Awards for the **construction of municipal collecting sewers** exceeded $410 million, topping record 1960, $359 million. Sewer and sewage treatment bond sales were running ahead of 1960.

**Contract awards for municipal water facilities construction** amounted to $575 million. Contract awards for water source and distribution facilities were slightly ahead of 1960 but those for treatment facilities construction were behind. Water bond sales each month in 1961 were lower than those in 1960.

### Public Assistance

During fiscal year 1961 **payments to public assistance recipients** totaled $3.9 billion. Of this amount 52 per cent was provided by the Federal Government, 36 per cent came from State sources, and the remaining 12 per cent from local sources.

About 2.3 million persons were **old-age assistance recipients** — some 60,000 fewer than at the beginning of 1961. They received payments totaling about $1.9 billion.

Nearly 3.4 million dependent children (and caretaker adults) were on the **aid-to-dependent-children** rolls at the end of 1961. Payments under this program from Federal, State, and local funds reached $1.1 billion.

In October, a year after the inception of **medical assistance for the aged (Kerr-Mills)**, 66,000 recipients were receiving $14 million monthly under the program.

### Vocational Rehabilitation

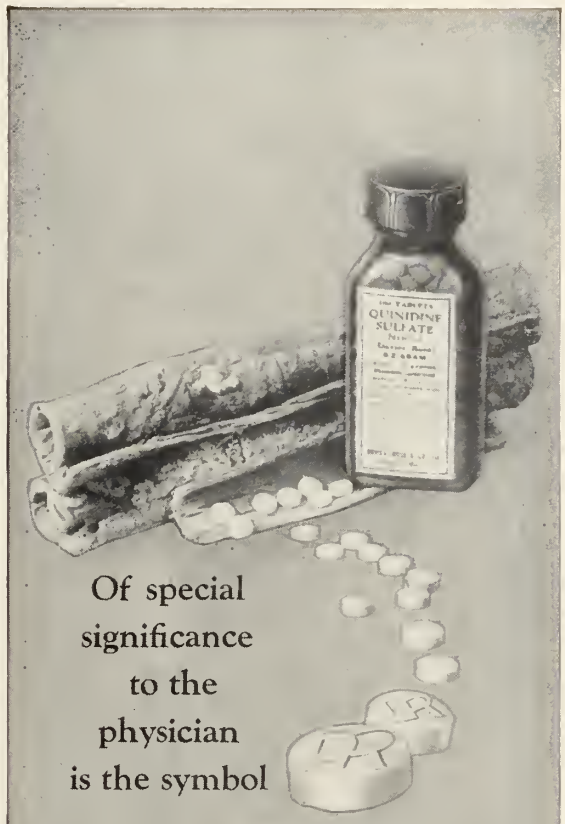
The number of **vocational rehabilitants** reached another all-time high in fiscal 1961 — 92,500 as compared with 88,300 in fiscal 1960. There were 287,100 **new referrals**, and 140,500 cases were **accepted for services**.

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## New Booklet Clarifies the Verbiage of Medicine

The verbiage of medicine has become so complicated that even physicians, professors, scientists and students aren't always sure what their colleagues are talking about. *Current Medical Terminology* (CMT), published this month by the American Medical Association, is designed to eliminate this quandary. Copies may be obtained from the AMA, 535 N. Dearborn St., Chicago 10, at $2.00 per copy.

Significant diseases have been catalogued in dictionary form along with their synonyms, causes, symptoms, signs, possible complications, usual findings and tests.


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# Activities of County Societies . . .

### BELMONT

At the September meeting of the Belmont County Medical Society, Dr. Jerry Hulka, assistant professor, Department of Obstetrics and Gynecology, University of Pittsburgh School of Medicine, spoke on the topic, "Office Gynecology."

It was announced that the October meeting of the society will be a joint meeting with the members of the Belmont County Bar Association. The speaker will be Dr. Emmerich von Haam, chairman of the Department of Pathology at the Ohio State University College of Medicine. Dr. von Haam's topic will be "Death of Medico-Legal Importance."

### FRANKLIN

The guest speaker at the September meeting of the Academy of Medicine of Columbus and Franklin County was Dr. Edward R. Annis, president-elect of the American Medical Association.

Dr. Annis is well known for his role as spokesman in the campaign against the King-Anderson Bill and as chairman of the AMA National Speakers Bureau.

### HAMILTON

The first meeting of the 1962-63 session was the Annual Meeting of the Academy of Medicine of Cincinnati, which was held on September 25. At that time the newly elected officers were introduced and annual reports of committees were presented.

### LUCAS

The Inter-Hospital Postgraduate Lecture Series presented by the medical advancement trust of Maumee Valley Hospital is scheduled to be held on October 4 and 5. The featured speaker for this two day program will be Dr. George E. Moore, director of the Roswell Park Memorial Institute in Buffalo, New York. Dr. Moore's topic will be "Review of Cancer Therapy and Research."

### MAHONING

The Mahoning County Medical Society sponsored a medical health tent for the eleventh consecutive year at the Mahoning County Fair, held in mid-August. Eighteen exhibitors joined with the medical society in presenting the local health picture to the general public.

The Canfield Fair committee begins early in the


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Spring with two meetings of former exhibitors to plan for the health tent. By charging for space, the medical society can underwrite the collective health exhibit.

This year, the medical society had two exhibits: "Life Begins," the popular AMA exhibit; and a local exhibit showing the society's mass polio immunization of last year and the two radio programs sponsored by the society.

Other exhibits were displayed by: The Mahoning Academy of General Practice, Youngstown Society for the Blind, Blue Cross-Blue Shield, Mahoning Cancer Society, United Cerebral Palsy Association, Mahoning Valley Podiatry Society, Corydon-Palmer Dental Society, Eastern Ohio Pharmaceutical Association, Youngstown Hearing and Speech Center, Youngstown Area Heart Association, Muscular Dystrophy, Mahoning Optometric Society, Safety Council of Greater Youngstown, Tuberculosis and Health Association, Youngstown Hospital Association, Planned Parenthood Association and the Woman's Auxiliary to the Mahoning County Medical Society.

An estimated 50,000 persons saw the exhibits in the medical health tent.

* * *

The Mahoning County Medical Society recently completed tabulations of its mass polio immunization program. The final distribution of Type III Sabin oral vaccine was on May 6 at 19 immunization stations.

Dr. Kurt Wegner, polio chairman, announced that 134,671 were immunized against Type I, 128,636 against Type II, and 131,650 against Type III, which amounted to approximately 65 per cent of the under-50 population of Mahoning County.

### PORTAGE

The Portage County Medical Society in cooperation with Kent State University presented an "Athletic Injury Conference" in late August.

The following topics were discussed: Soft tissue injuries, dental injuries, heart conditions in athletes, knee injuries, ankle injuries, and a taping demonstration was presented.

### STARK

The Stark County Medical Society was entertained recently when the Stark County Pharmaceutical Association held its 12th annual pharmacists-physicians stag. Speakers included Dr. Graydon Underwood, president of the Stark County Medical Society and Howard Garrett, president of the pharmacists' group.




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## American College of Ob.-Gyn. District V Meeting

Several Ohio physicians will participate in the forthcoming annual meeting of District V, American College of Obstetricians and Gynecologists, November 8-10 at the Sheraton Lincoln Hotel, Indianapolis, Indiana.

Dr. David A. Bickel, Cleveland, and Dr. Joseph G. Crotty, Cincinnati, will participate in a panel discussion on Geriatric Gynecology.

Case Reports will be presented by Dr. Albert Hirsheimer, Dayton, on "Postpartum Serratus Magnus Paralysis," and by Dr. C. Roger Moritz, Dayton, on "Abdominal-Menstrual Fistula."

Dr. Anthony Ruppersberg, Jr., Columbus, will be chairman of a Maternal Mortality Conference.

Dr. John E. Doolittle, Dayton, will present a paper on "Placental Vascular Integrity Related to Third State Management."

Dr. Clarence McClain, Dayton, will present a paper on "Amniography, An Aid to Obstetric Diagnosis."

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Dr. Charles A. Anderson, Warren, is the president general of the National Society of the Sons of the American Revolution.

## Ob-Gyn Nurses Conference Is Scheduled in Indianapolis

The annual Ob-Gyn Nurses' Conference, sponsored by District V of the American College of Obstetricians and Gynecologists is scheduled in Indianapolis, Indiana, at the Hotel Severin, November 8-9. Ohio is in District V, as are Kentucky, Michigan, Indiana and Ontario.

Several Ohioans are on the program.

Dr. Anthony Ruppersberg, Jr., Columbus, chairman of the OSMA Committee on Maternal Health, will moderate a panel discussion on "Maternity Nurse In-Service Education — Team Approach."

Dr. Charles E. Black, Toledo, will moderate a round table discussion on "The Use of X-Ray During Pregnancy."

Ohio nurses on the program include, Miss Laurine Cockran, Cincinnati; Sister Marie Ellen, Cincinnati; Sister M. Finbarr, Youngstown; Miss Eleanor Walsh, Toledo; and Mrs. Ann Sedlemaier, Columbus.

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The manner in which living cells respond to radiation will receive intensive study in a comprehensive research program at the University of Maryland School of Medicine in Baltimore, the Public Health Service announced.


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Important: Before prescribing DBI-TD, the physician should be thoroughly familiar with directions for use, including indications, dosage, possible side effects, precautions and contraindications. Write for complete literature.

1. Pomeranze, J.: Clinical Med. 8:1155, June 1961. 2. Krall, L. P. and Bradley, R. F.: Geriatrics 17:337, May 1962. 3. DeLawter, D. E. et al.: J.A.M.A. 171:1786, Nov. 28, 1959. 4. Perkin, F. S.: J.A.M.A. 173:36, May 7, 1960. 5. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 6. Radding, R. S. et al.: Metabolism 11:404, April 1962. 7. Gold, A. et al.: Applied Therapeutics 2:137, 1960. 8. Brown, G. D. and Gabert, H.: Applied Therapeutics 4:451, May 1962. 9. Gold, A.: Applied Therapeutics 4:466, May 1962.

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Out of the Blue

# Home and Most Office Visits Are Not Insurable Risks

By R. DEAN DOOLEY, M.D.

Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

I AM frequently asked why O. M. I. cannot indemnify home calls and more office procedures. To answer this question one must first inquire as to the extent of coverage desired, keeping in mind that the less risk the insured desires to assume the greater the premium he must pay for his insurance. It is axiomatic that premiums increase in direct proportion to the risk factor. When the risk factor for the insurance company reaches a point of totality, it is no longer insurance but dollar financing.

### Lesson of Auto Insurance

The growth in popularity of the prepayment idea has been phenomenal and the popular concept of insurance has gradually reached the point that prepayment insurance today is assumed to be all-inclusive and capable of relieving its subscribers of further responsibility in financing the cost of health care.

Health insurance cannot be all-inclusive if it is to present a program at an acceptable premium rate, any more than automobile insurance can offer moderately priced comprehensive coverage. The premium on auto insurance is kept at a reasonable level because the insured accepts a portion of the risk through the mechanism of deductibles. In other words, the insured pays for the small fender dents and other small expenses out of pocket. The insurance company comes to the aid of the insured in assisting the policyholder to meet the cost of the major accident. The small expense is no serious strain on the budget; however, the cost of repairing the car after a serious accident could well be a financial catastrophe.

### Premium Would Be Excessive

The same principle applies to health insurance. Every family will have a certain number of house and office calls as an annual recurring expense. These are the fender dents which can be more economically paid out of pocket. Insurance on a house would be inordinately high if it were written to cover the normal deterioration of paint, spoutings, gutters, etc. These are recurring expenses which the home owner expects and prepares for them as they occur.

The coverage of home and office calls would demand a tremendous increase in the premium rate and, in many instances, would price the insurance beyond the means of many people, thus weakening its effectiveness and constituting a threat to the voluntary prepayment system. By covering the expected and recurring family health care costs for which a provident family should make adequate plans, many families would be deprived of coverage for the unpredictable and catastrophic expenses.

### Must Not Overextend

It has been asked why we do not make use of the deductible principle employed by other types of insurance referred to earlier, notably the automobile insurance industry. Actually, we do make use of deductibles by excluding the recurring small and less troublesome expenses even though it is not expressed in specified dollar amounts. Many insurance companies employ some form of a dollar deductible mechanism. As a rule this is not well accepted.

After fifteen years of service to the people of Ohio we are convinced it is better to pay adequate amounts for the expensive items than to overextend our coverage with a consequent limitation of payments for the more costly items which put a strain on the family budget. The temptation to overextend in an effort to outbid competition is a dangerous practice.

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### Ohio Virologist

One of the two physicians who were credited recently with isolation of the German measles virus is an Ohioan, Dr. Gilbert M. Schiff, graduate of the University of Cincinnati College of Medicine. He and Dr. John L. Sever, pinpointed the virus as virologists on the staff of the National Institute of Neurological Diseases and Blindness, Bethesda, Md. Dr. Gilbert Schiff is the son of Dr. Leon Schiff, director of the UC Medical Center's Gastric Laboratory at the Cincinnati General Hospital.

# Logical support for the atherosclerosis diet

A recent report* in the *JAMA* on atherosclerosis states, "...it appears logical to attempt to reduce high concentrations of cholesterol and other serum lipids as an experimental therapeutic procedure."

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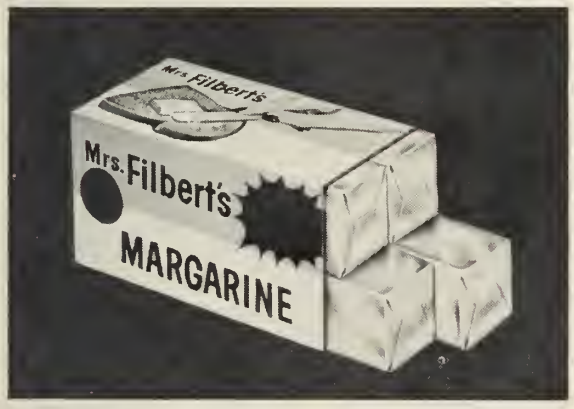
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*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181: 411-423 (August 4, 1962).




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**Mrs. Filbert's Margarine** is a popular, conventional-type margarine with no premium price. It is made from the finest domestic vegetable oils, which are partially hydrogenated for texture, but remain over 80% unsaturated. It has a ratio of polyunsaturates to saturates in excess of 1 to 1.




**Mrs. Filbert's Whipped Margarine** contains the same number of calories per pound as ordinary margarine, but contains 30% *fewer calories per pat* because it is whipped. When spread normally, it provides satisfaction with a reduction in fat calories. And its ratio of polyunsaturates to saturates exceeds 1 to 1.

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# Activities of Woman's Auxiliary...

CHAIRMAN, PUBLICITY COMMITTEE—Mrs. Rivington Fisher, 549 Eastmoor Blvd., Columbus 9, Ohio
(Roster of Officers, Page 1199)

## CUYAHOGA

Community projects have occupied the time of many Cleveland Academy Auxiliary volunteers. Members devoted some 500 hours to the highly successful drive to immunize the residents of Greater Cleveland against polio.

Close to one and a half million residents — roughly 90 per cent of the population — received Types I, II and III polio vaccine via sugar cubes. Expenses were completely defrayed by voluntary contributions. Cleveland's campaign has received national attention for its efficient organization and success.

The Auxiliary also was one of 16 groups sponsoring 1962 Civic Fellowship Tour to three Red Feather — Red Cross agencies on June 4.

Other summer activities included a Family Day at Euclid Beach Park July 19 and the presentation of the Practical Nurse's Award by Mrs. Stanley DeVille to Miss Caroline Acela of Lakewood Hospital.

Two members, Mrs. Rudolph Cooks and Mrs. C. A. Colombi, are serving on the Mayor's Safety Education Committee. The Auxiliary was presented a second place award in the Mayor's Award Program at the Seventh Annual Safety Rally and Tea August 1. The group's campaign started with a Family Safety Pledge and a Halloween Traffic Safety Parade. It also included a seat belt crusade and distribution of safety information.

Mrs. Garry G. Bassett, international health chairman, has been participating in the fund raising efforts for Project Hope. A door-to-door campaign is underway and cannisters have been placed throughout the city.

Auxiliary members also are collecting old clean sheets, medical instruments, text books, and samples for shipment abroad. Mrs. W. James Gardner, chairman, reports that approximately $30,000 worth of medical samples collected during the past year are ready to be checked and packed.

Proceeds from the sale of Christmas cards, the Memorium Fund and the Chrysanthemum Ball, scheduled November 3, will benefit the AMERF.

The Auxiliary opened its fall activities with a luncheon at the Yacht Club September 6, climaxing a membership drive. Mrs. Eugene Gessler, new president, welcomed the membership aboard the Goodtime II for an afternoon cruise.

## FAIRFIELD

New officers of the Woman's Auxiliary to the Fairfield County Medical Society were installed by Mrs. Galon Rodabaugh May 14 when the group met for luncheon at the home of Mrs. Chester Swett.

Taking office were: Mrs. Richard Welsh, president; Mrs. Andrew Essman, vice president; Mrs. John Edwards, president-elect; Mrs. L. H. Urling, secretary; and Mrs. C. B. Crow, treasurer. Mrs. Welsh announced names of her committee chairmen.

Mrs. Jack Kraker is the immediate past president. Assisting hostesses at the meeting were Mrs. Rodabaugh, Mrs. M. E. Nichols, Mrs. J. W. Boswell and Mrs. Milliken.

Mrs. Jasper announced that 60 girls had joined the Future Nurses Club and that 16 of them had agreed to work as junior volunteer Candy Stripers during the summer months.

Mrs. Essman showed color slides of activities at the Cerebral Palsy Center — one of the Auxiliary's projects. Mrs. Kraker, Mrs. Edwards and Mrs. George

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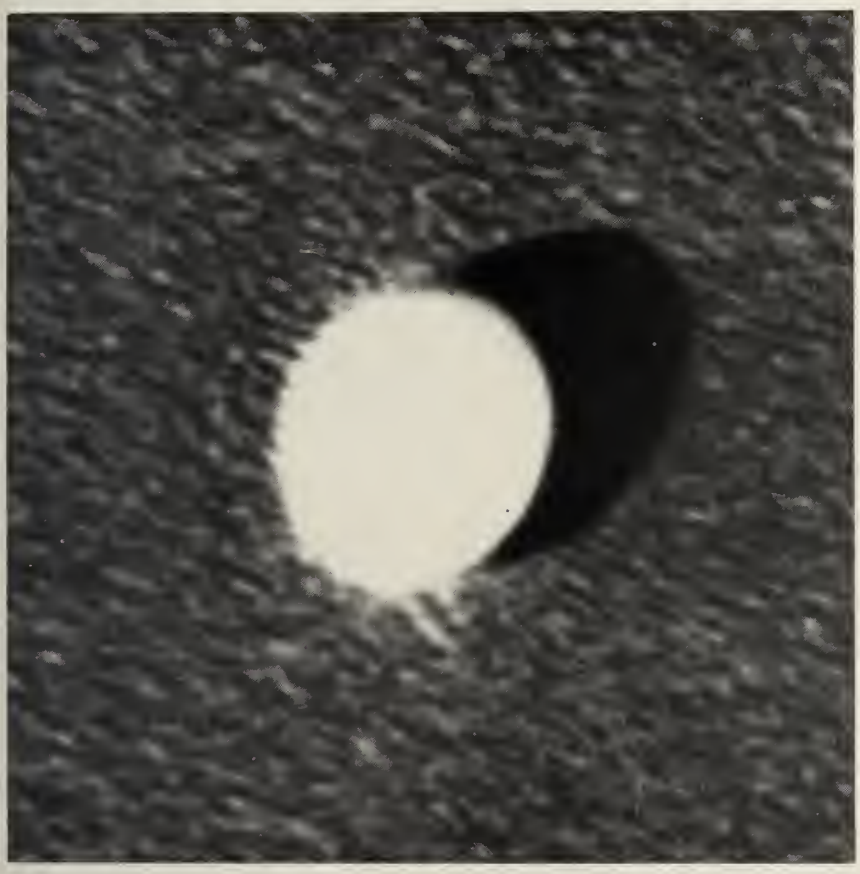
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LeSar reported on the special legislation discussed at a meeting of the Franklin County Auxiliary.

### FRANKLIN

Mrs. Harold I. Humphrey, new president of the Woman's Auxiliary to the Academy of Medicine of Columbus and Franklin County, was scheduled to open the 1962-63 activities of the group September 17.

Mrs. Humphrey and her co-officers were installed May 21 at Green Meadows Inn by Mrs. Robert H. Schoene. Other officers are: Mrs. Charles W. Pavey, president-elect; Mrs. Robert A. Heilman, vice president; Mrs. Carl E. Tetirick, recording secretary; Mrs. John D. White, corresponding secretary; Mrs. Ben Arnoff, treasurer; and Mrs. John P. Riepenhoff, assistant treasurer. Committee chairmen also were named.

A 22-year history of the Auxiliary was completed recently by Mrs. William F. Bradley, Mrs. A. L. Kefauver and Mrs. George Cooperider.

Mrs. Alfred Slivinski, AMERF chairman, reports that the Auxiliary's total as of May 1962 amounts to $1,193.

The group received a certificate of achievement and recognition — the highest award given by the Ohio State Medical Auxiliary — during the state convention in May.

Mrs. John W. Means, community service chairman, her committee and 46 other Auxiliary members, have screened more than eight thousand children for the Franklin County Tuberculosis Society at 107 Columbus public and parochial schools. This represents 214 work days.

The program will be resumed in October in the suburban schools. The goal is to do testing in 126 schools before the first week in December. The second phase of the testing will begin in January, 1963, in 165 Columbus schools.

A total of approximately 300 schools will be included in the 1962-63 program according to Mrs. Means and Mrs. Wynsen, community service co-chairmen.

Mrs. Floyd Beman, scholarship chairman, presented a three-year scholarship to Loraine Schuh who will enter Mt. Carmel School of Nursing. In addition the Auxiliary is assisting two girls enrolled in a four-year program to obtain their bachelor of science degrees in addition to their "R. N.'s."

Scholarships also are provided to four girls enrolled in three-year courses to obtain their "R. N.'s."

### HAMILTON

The Woman's Auxiliary to the Academy of Medicine of Cincinnati accepted the responsibility — at the request of the Health Department and the Academy of Medicine — for supplying volunteers in schools throughout the city for the first Sabin Oral Vaccine Sunday.

Members distributed some 375,000 registration blanks in shopping centers, drive-in theaters and gas stations. Volunteers also telephoned industries for distribution of an additional 100,000 blanks to employees, and made arrangements for spot announcements through radio and television.

In addition the volunteers assembled information kits and answered telephones at the Academy regarding the program and assisted in recruiting doctors to work in the schools.

### SUMMIT

The annual garden party and hat show of the Woman's Auxiliary to Summit County Medical Society took place August 16 at the home of Dr. and Mrs. Milton I. Friedman. Proceeds were for the Betty Dobkin Scholarship Fund. Mrs. Robert S. McMillen served as chairman.

Organization of the Sabin for Summit program is being completed by Mrs. C. J. DeWinter, chairman, and Mrs. A. H. Kyriakides, co-chairman. Some 40 stations have been selected with members to serve as volunteers.

## Surgeons' Mid-West Meeting Scheduled in Des Moines

The International College of Surgeons Mid-West Regional meeting will be held at the Hotel Savery, Des Moines, Iowa, October 31 - November 1. Further information may be obtained from Bernard Barnes, M. D., 803 Equitable Building, Des Moines, Iowa.


**COOK COUNTY GRADUATE SCHOOL OF MEDICINE**

CONTINUING EDUCATION COURSES
STARTING DATES — FALL, 1962

Surgical Technic, Two Weeks, November 5
Surgery of Colon and Rectum, One Week, November 26
Vaginal Approach to Pelvic Surgery, One Week, Dec. 17
Gynecology, Office & Operative, Two Weeks, November 5
Obstetrics, General & Surgical, Two Weeks, November 26
Urology, Two Weeks, October 29
Proctoscopy & Sigmoidoscopy, One Week, Oct. 29, Dec. 17
Varicose Veins, One Week, Oct. 29, Dec. 17
General Surgery, One Week, October 29
Advances in Medicine, One Week, October 15
Advances in Surgery, One Week, December 10
Blood Vessel Surgery, One Week, October 22
Board of Surgery Review, Part I, Two Weeks, Nov. 5
Board of Surgery Review, Part II, Two Weeks, Nov. 26
Diagnostic Radiology, Two Weeks, October 29
Basic Internal Medicine, Two Weeks, November 5
Management of Common Fractures & Dislocations, One Week, December 3
Board of Internal Medicine Review, Part II, One Week, December 3

*Information concerning numerous other continuation courses available upon request.*

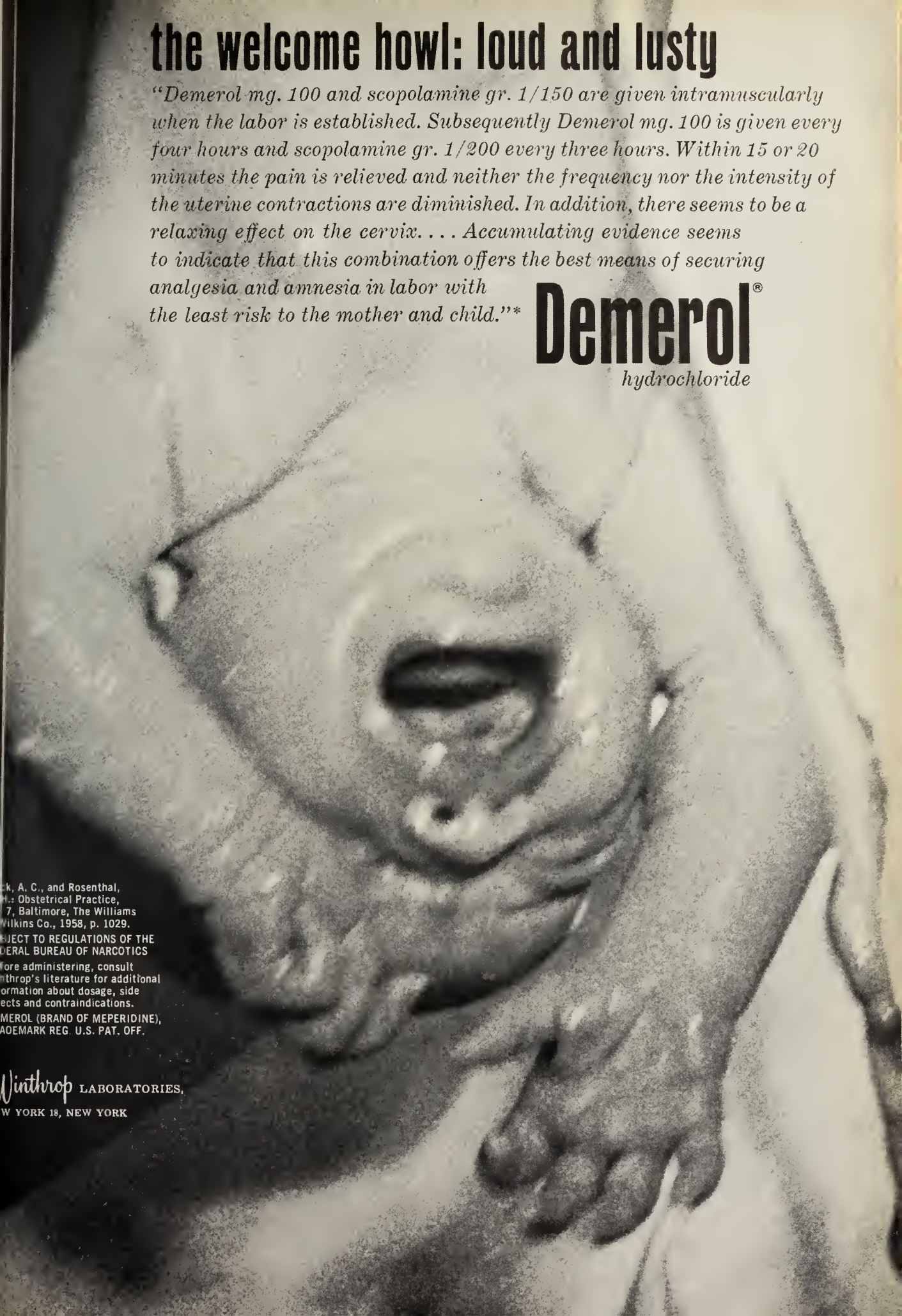
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k, A. C., and Rosenthal,
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7, Baltimore, The Williams
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OB-GYN man, Residency trained — 3 years, Board eligible; Seeking Association or an area where services are needed. Available March 1963. Box 287, c/o Ohio State Medical Journal.

PSYCHIATRISTS or OTHER PHYSICIANS Wanted for 800 bed mental hospital located in medium-sized northern Ohio city near Lake Erie resort areas. Ohio licensure and/or ECFMG certification preferable but not required. Salary from $575 to $1,250 per month depending on training and experience. Furnished apartments with free utilities provided at nominal rates. Reply to: Howard R. Barton, M. D., Clinical Director, Tiffin State Hospital, Tiffin, O.

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# Coming Meetings . . .

(See also Schedule of Postgraduate Courses in Ohio, beginning on page 1165.)

**American College of Surgeons,** Clinical Congress, Atlantic City, October 15 - 19.

**American Medical Association,** Clinical Meeting, Los Angeles, Calif., November 25 - 28.

**Ohio State Medical Association,** Annual Meeting, Cleveland, week of May 12, 1963.

## Cleveland VA Office Holds Clinical Conferences

The Cleveland Regional Office of the Veterans Administration has announced resumption of its series of clinical conferences. Sessions are held in the Conference Room, 2nd Floor, Cuyahoga Building on Wednesdays from 8:00 to 9:00 a. m. Dr. Charles Berns is conference chairman.

Subjects for discussion in late October and November are the following:

October 17—Presentation of Some Diseases of the Large Bowel, Dr. S. Krohn.

October 24—Rhinoplasty, Dr. J. G. Himmel.

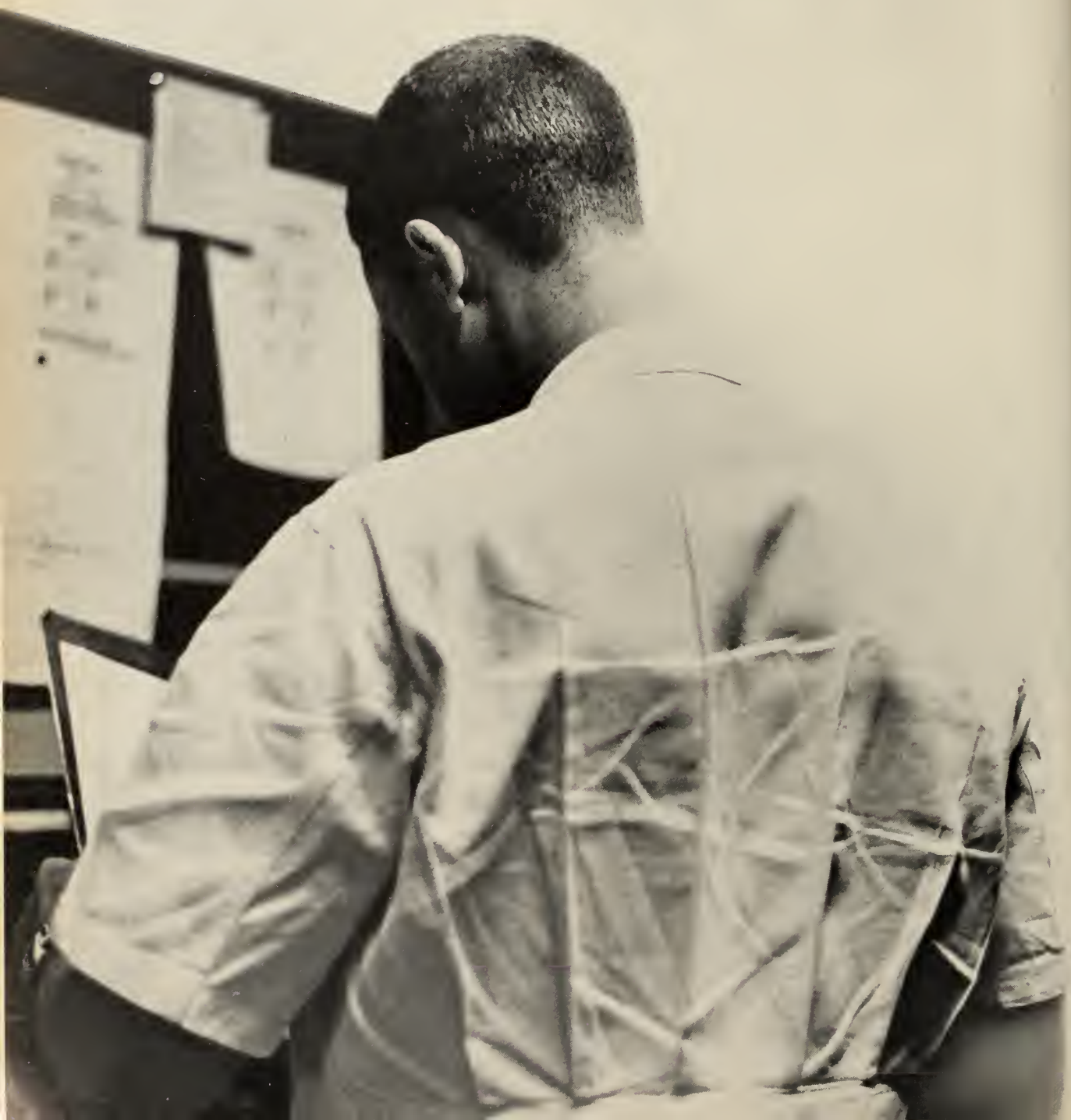
October 31—The Case Against Annual Physical Check-Up Examinations, Dr. Oscar Rosen.

November 7—Psychological Research in VA, H. S. Curtis, Ph. D., and M. S. Slobin, Ph. D., Psychology Department.

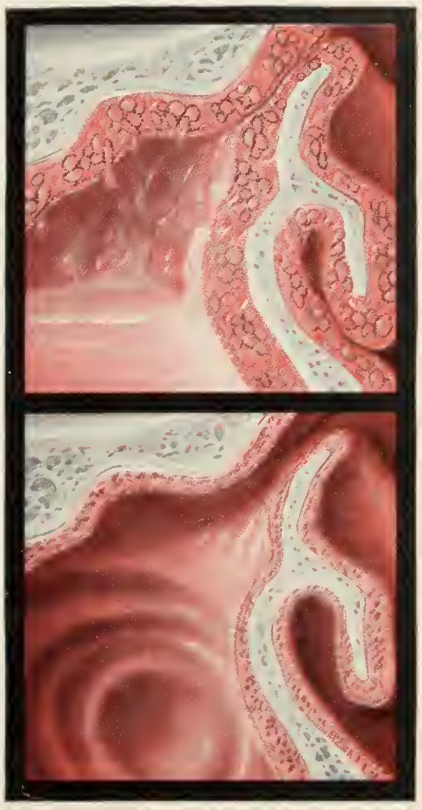
November 14—Streptomycin Ototoxicity (a 10-Year Comparative Study), Dr. William F. Hulse.

November 28—Dental Problems in VA Regional Office, Al W. Johnson, D. D. S., and C. D. Miller, D. D. S.

**in urinary tract infections...**
**the most common pathogens**
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In sinusitis, the mucous membrane becomes hyperemic and edematous, lymph glands and goblet cells hyperactive. Ostium is closed by edema and secretions cannot drain freely.

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## NASAL SPRAYS AND SOLUTIONS

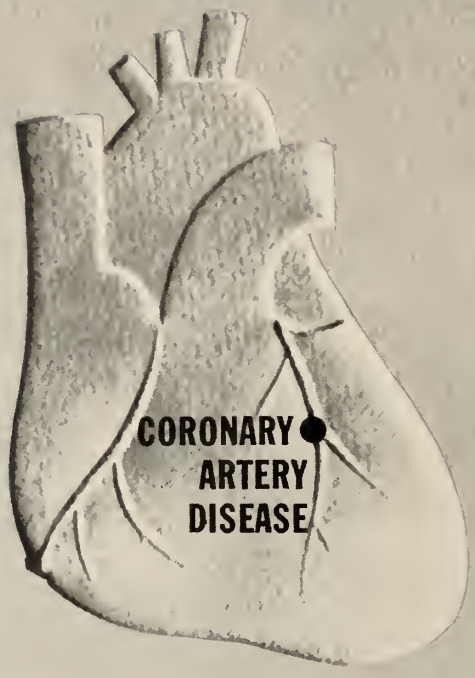
When there is nasal turgescence, tiny orifices of sinus ostia tend to clog. Neo-Synephrine nasal solutions and sprays reduce edematous tissues on contact to provide prompt relief. As turbinates shrink, obstructed sinus ostia open, drainage and breathing become freer and the boggy feeling of a cold disappears.

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**1.** Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. **2.** Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. **3.** Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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*References:* (1) Root, H. F., and Bradley, R. F., in Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 10, Philadelphia, Lea & Febiger, 1959, pp. 411, 437. (2) Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: *ibid.,* pp. 188-189. (3) Marks, H. H., *et al.:* Diabetes *9*:500, 1960. (4) Marble, A., in Summary of Conference on Diabetic Retinopathy, Survey Ophth. (Part 2) *6*:611-612, 1961.

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**Bibliography: 1.** Cohen, A., et al.: J.A.M.A. 165:225, 1957. **2.** Spies, T.D., et al.: J.A.M.A. 159:645, 1955. **3.** Moravec, C.L. and Moravec, M.E.: Clin. Med. 7:2322, 1960. H-416

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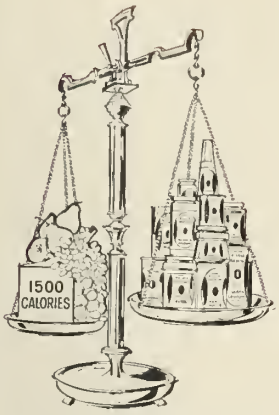
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| Chopped Chicken Livers | 1 oz. | 31 | 100 |
| Chicken a la King | 3 oz. | 72 | 230 |
| French Style Dressing | 1 tbsp. | 10½ | 60 |
| Brown Gravy | 1 tbsp. | 7 | 21 |

| | Quantity | Figure Control Calories | "Regular" Food Calories |
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| Chocolate Topping | 1 tbsp. | 8 | 63 |
| Preserves (Peach, Strawberry) | 1 tbsp. | 9 | 55 |
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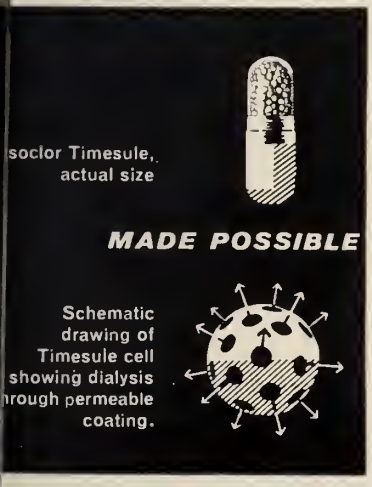
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**WARNING:** Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

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**IN BRIEF** The dependability of Terramycin in daily practice is based upon its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using.

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INDICATIONS AND DOSAGE: For the following indications, the recommended daily dosage is one or two 'Dexedrine' *Spansule* capsules, usually taken in the morning: control of appetite in weight reduction; depressive states; alcoholism. In narcolepsy, the recommended daily dosage is up to 50 mg. of 'Dexedrine' by 'Spansule' capsule on arising.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

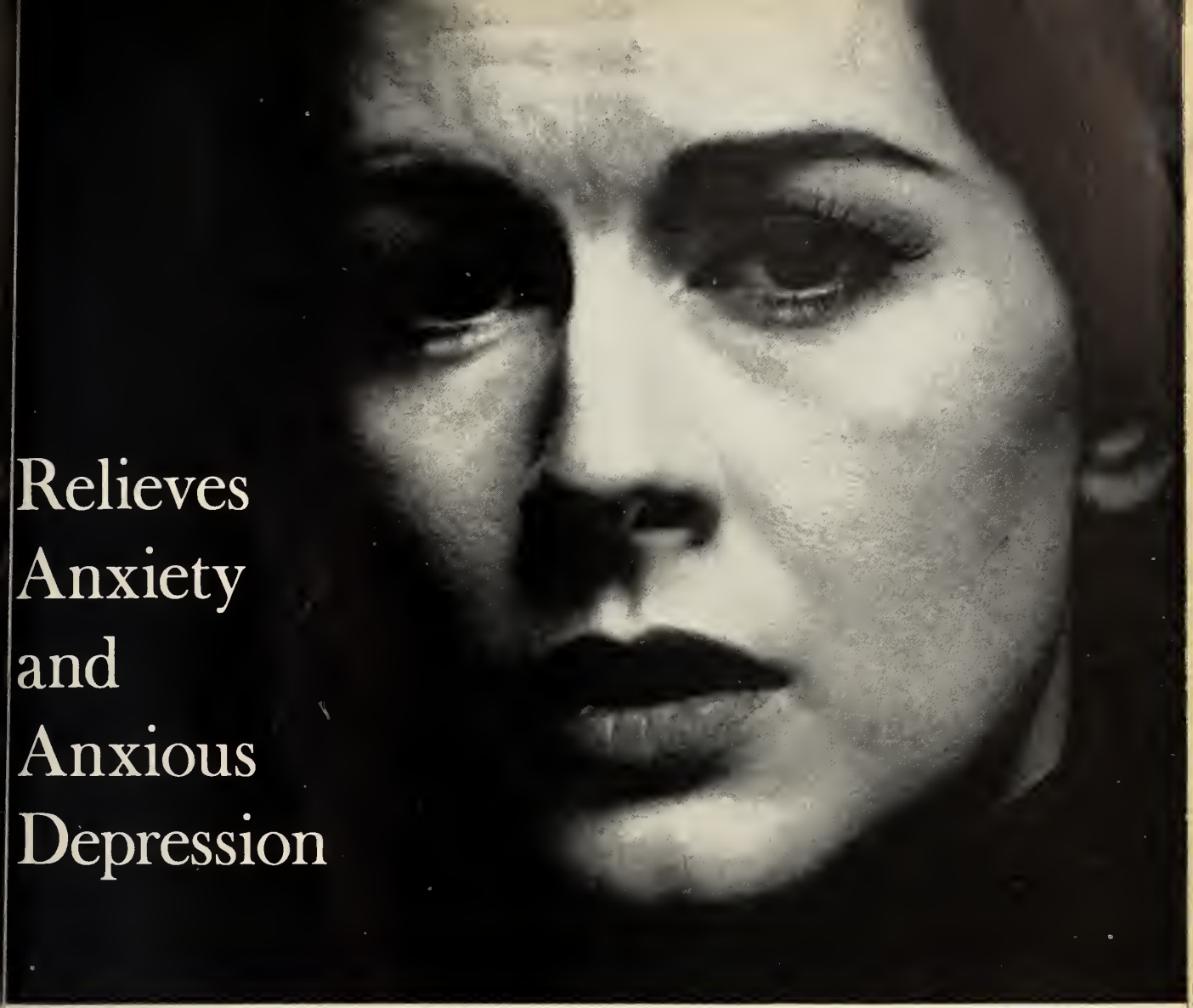
CAUTIONS: Should be used with caution in patients hypersensitive to sympathomimetic compounds; in cases of coronary or cardiovascular disease; and in the presence of severe hypertension.

CONTRAINDICATIONS: Hyperexcitability; agitated pre-psychotic states.

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*Prescribing information adopted January 1961.*

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1. Groskloss, H.H., Clancy, C.L., Healey, E.F., McCann, W.J., Maloney, F.D., Loritz, A.F.: Clinical Medicine (Sept.) 1955.

Study involving 287 patients. 261 patients experienced excellent to good results with Bonadoxin for relief of nausea and vomiting of pregnancy. No side effects reported.[1]

2. Albertson, H.A., Trout, Jr., H.H., Daily, F.W.: The American Journal of Surgery (Sept.) 1956.

"As a result of this study, it is our belief that the routine prophylactic use of the combination of meclizine hydrochloride and pyridoxine is a safe and effective method for lessening the incidence of postoperative nausea and vomiting. We are employing this preparation as a routine pre-operative medication."[2]

3. Goldsmith, J.W.: Minn. Med. (Feb.) 1957.

Study involving 620 patients, 537 patients experienced moderate to complete improvement of nausea and vomiting of pregnancy with Bonadoxin. Toxicity and intolerance to the medication in the dosage employed in these studies was zero.[3]

4. Codling, J.W.; Lowden, R.J.: Northwest Med. (March) 1958.

Study involving 76 pregnant patients with nausea and vomiting. The results indicated an overall response in 70 of 76 patients treated. No side reactions were observed in this clinical study.[4]

5. Bentley, M.D.: Journal of the Mich. State Med. Soc. (Sept.) 1959.

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6. Bethea, R.C.: International Record of Med. (May) 1960.

"Our investigation of this drug indicates that in 88 per cent of the cases satisfactory relief of the distressing symptoms of early pregnancy was obtained without undesirable side effects, including sedation."[6]

7. Sklaroff, D.M.; Karayannis, N.: Current Therapeutic Research (June) 1962.

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**Pathology of the Lung,** by H. Spencer, M. D. ($30.00, *The Macmillan Company, New York 11, New York.)* Clearly written and profusely illustrated, this text deals exhaustively with pathology of the lung, correlating pathology with physiology wherever such correlation is possible. Although it is clearly not a book that will be found in the library of every practicing physician, it could well serve as the ultimate, authoritative reference for a long time to come. Its importance is well summarized in the Foreword by Dr. A. A. Liebow as follows: "A man's medical history, and the traces of his habits and his trade are often inscribed upon the lungs — for him who can read. Not since the monumental contribution of Fischer in the Handbook of Henke-Lubarsch, have the lungs been so thoroughly or so well read, and the reading so well recorded as in this volume . . . Only a rare concurrence of meticulous scholarship and discernment could have enabled the condensation of so much information into so little space. This work will long be of interest and value to all students of disease."

**Respiration; Physiologic Principles and Their Clinical Applications,** by P. H. Rossier, A. A. Bühlmann, and K. Wiesinger, edited and translated from the German Edition by Peter C. Luchsinger, M. D., and Kenneth M. Moser, M. D. ($15.75, *The C. V. Mosby Company, St. Louis 3, Mo.)* This is a comprehensive text dealing with cardiopulmonary physiology and its clinical implications. It is a translation of a German text that is already in its second edition. Of primary interest to physicians working in the fields of physiology and pulmonary diseases, it should serve as an excellent reference for others.

**Respiration in Health and Disease,** by R. M. Cherniack, M. D., and L. Cherniack, M. D. ($10.50, *W. B. Saunders Company, Philadelphia 5, Pa.)* Throughout this text, emphasis is, as it must be, upon basic respiratory physiology. However, this is by no means a textbook of physiology nor is it intended to treat that subject exhaustively. The authors have succeeded in correlating basic knowledge with clinical observations in a manner that should be easily read and understood by the relatively uninitiated. For example, a 14 page chapter entitled The Functional Assessment summarizes the subject of pulmonary function tests in a manner entirely adequate for the practicing physician.

This book is highly recommended for your office library.

**Surgical Diseases of the Chest,** by Brian Blades, M. D., and contributors. ($22.00, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

**Clinical Cardiopulmonary Physiology,** by Burgess L. Gordon, M. D., and Ross C. Kory, M. D. ($28.50, Second edition, *Grune & Stratton, Inc., New York 16, New York.)*

**Chest Pain:** Systematic Differentiation and Treatment, by Nathaniel E. Reich, M. D., and Rudolph E. Fremont, M. D. ($9.00, *The Macmillan Company, New York 11, New York.)*

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**Drug Therapy,** by Frank C. Ferguson, Jr., M. D. ($7.50, *Lea & Febiger, Philadelphia 6, Pa.)*

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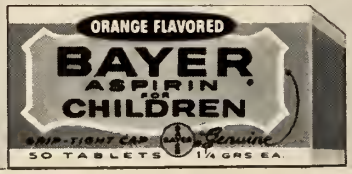
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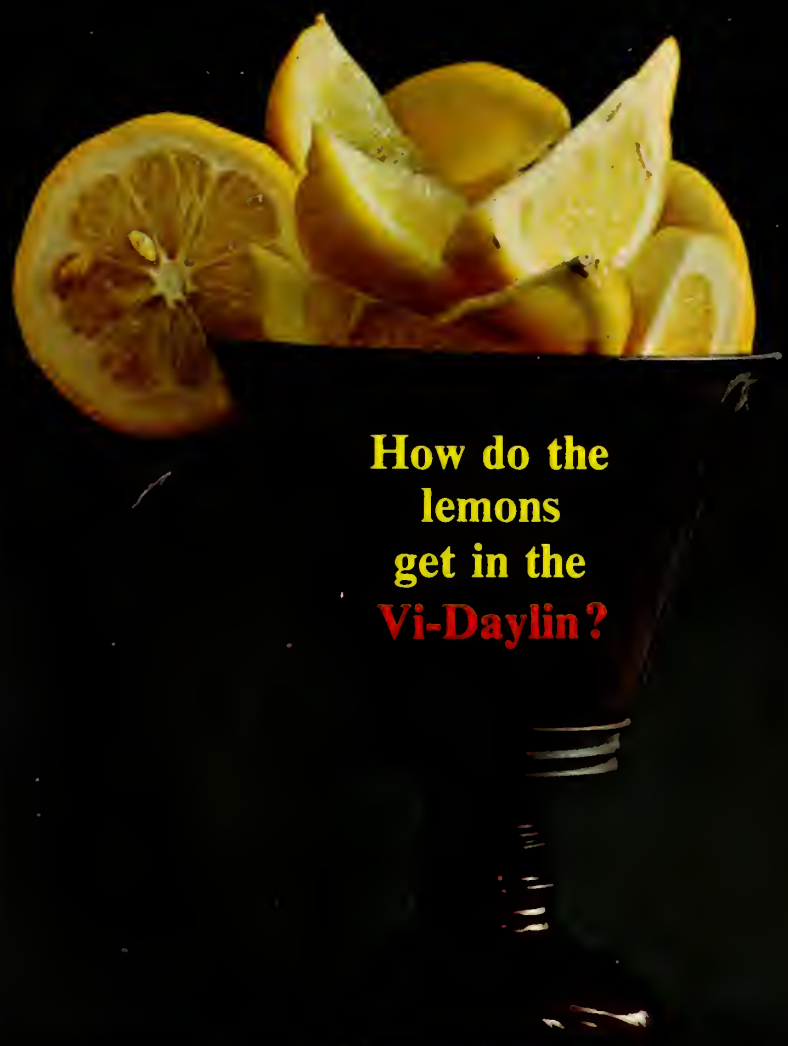
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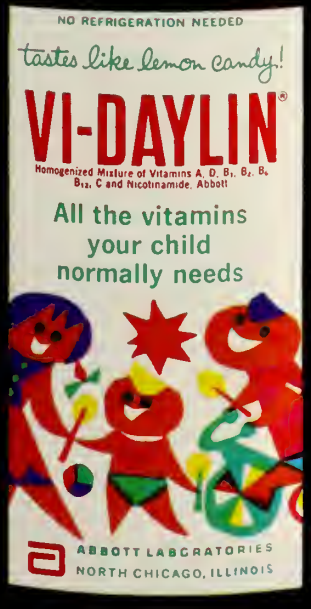

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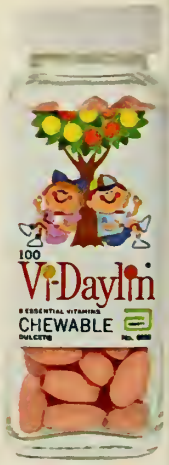
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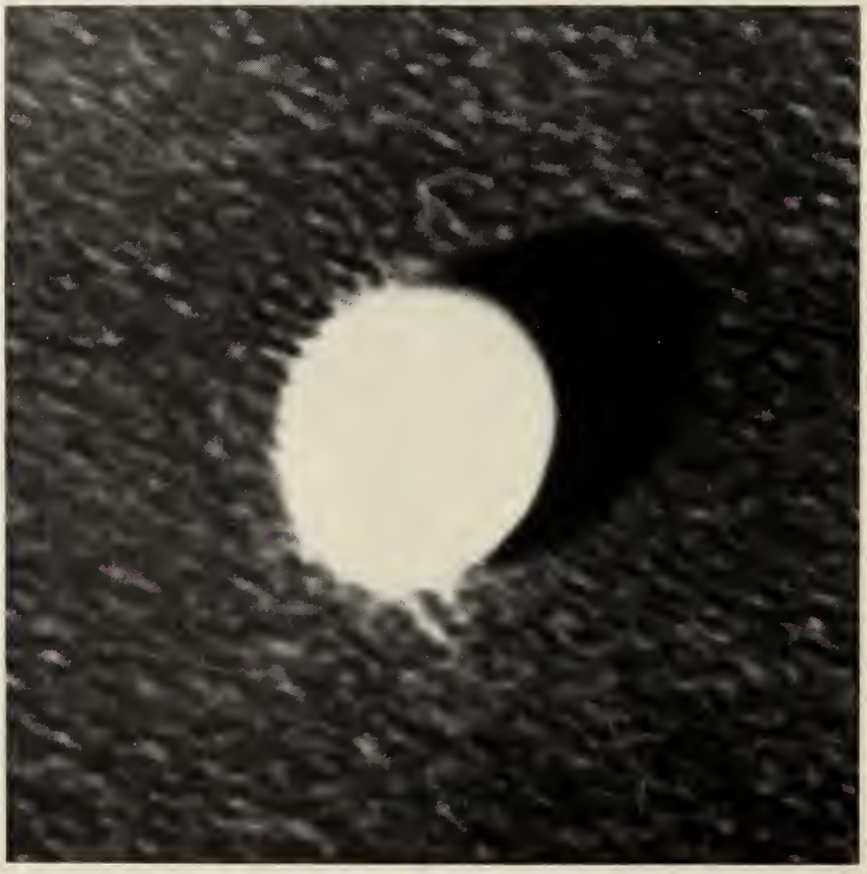
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1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

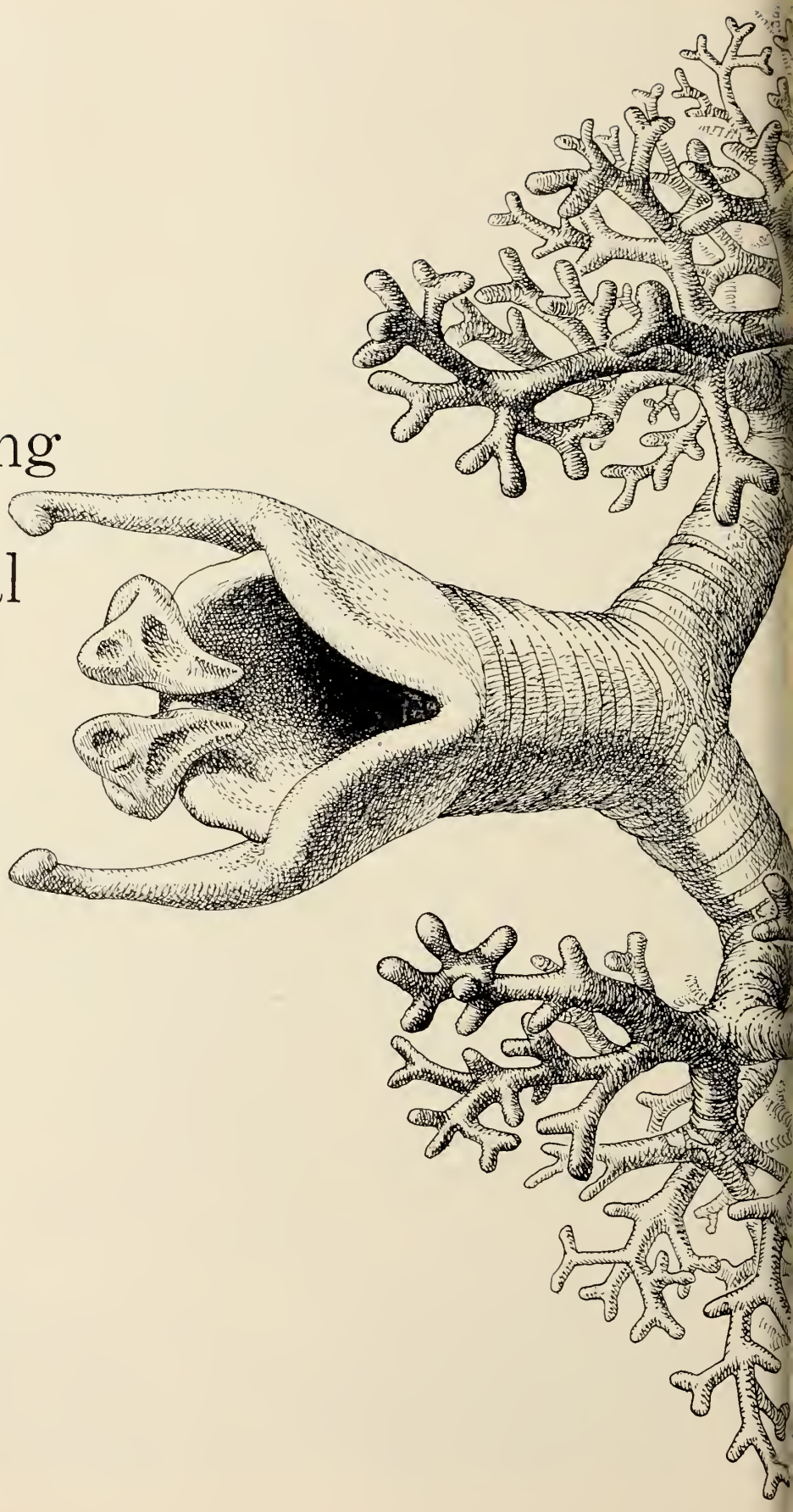
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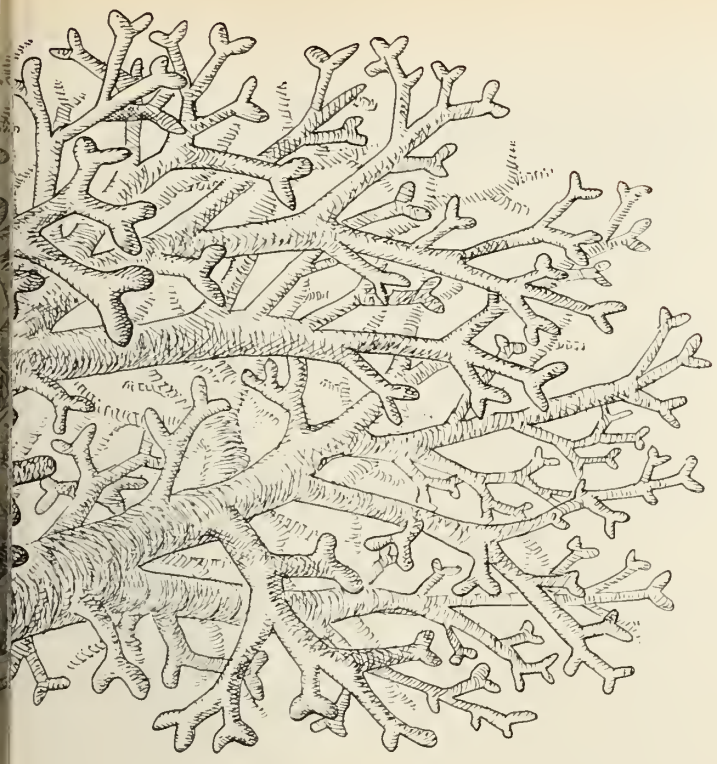
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| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
| Toledo | Toledo Health Department<br>635 N. Erie St. | CH 4-1961—(Day)<br>EV 5-4661—(Night) |
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| Ephedrine sulfate | 12 mg. |
| Theophylline | 45 mg. |
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| Alcohol | 19% |

*Adult Dose:* 2 tablespoons 3 or 4 times daily.

*How Supplied:* Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

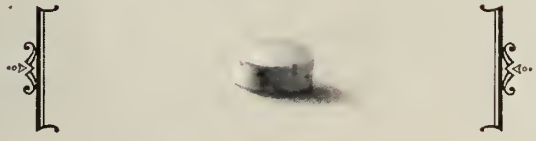
Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

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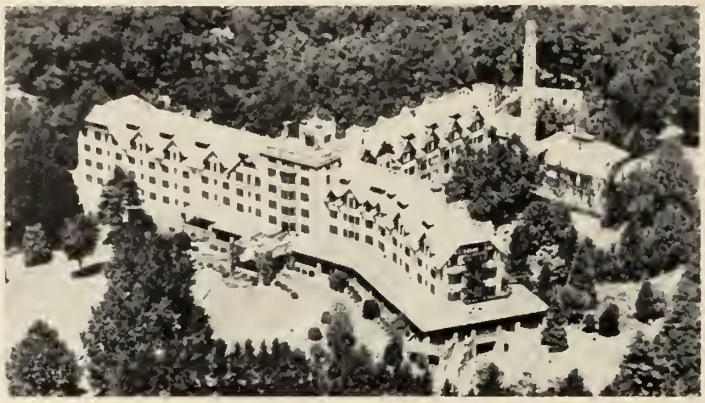
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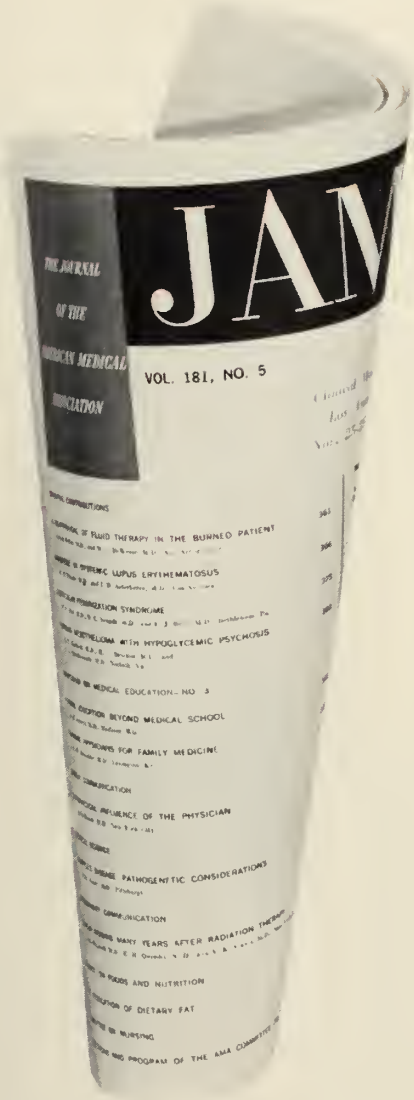
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1. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No. 2, February, 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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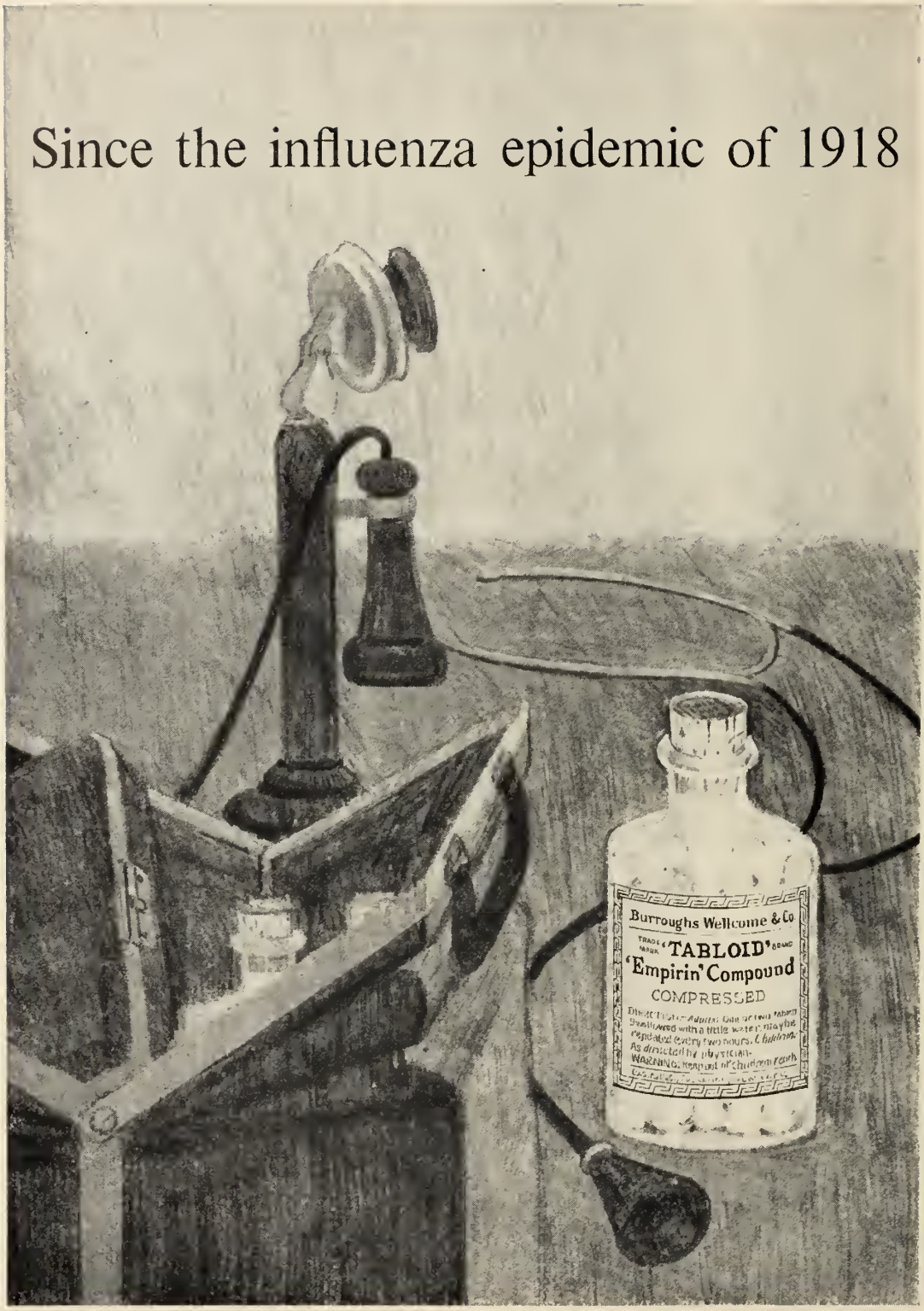
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Simon, F. & Bernstein, A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, 32-37, Jan. 1961.

Plotz, M.: Modern Management of Obesity, J.A.M.A., 170:1513-1515 (July 25) 1959.

Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clinical Medicine, 907-920, May 1961.

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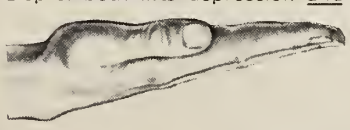
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**Dosage:** Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

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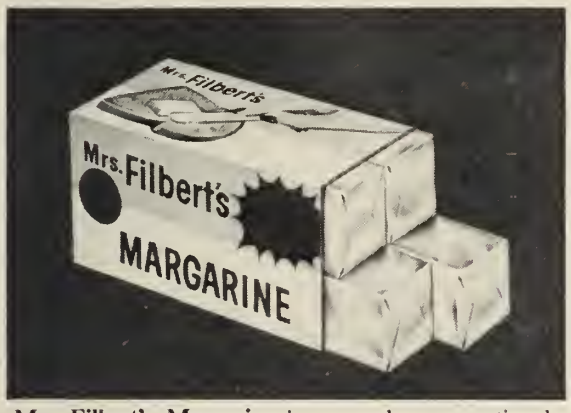
Each of Mrs. Filbert's Margarines is over 80% unsaturated and offers unique properties useful in the control of serum lipids by dietary means.

Moreover, when you recommend any one of Mrs. Filbert's Margarines, your patient is assured of unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181: 411-423 (August 4, 1962).




**Mrs. Filbert's Corn Oil Margarine** is made from 100% corn oil, over 50% of which retains its *liquid* characteristics. Because of its high linoleic content, its ratio of polyunsaturates to saturates exceeds 1.5 to 1 . . . and equals the highest level available today in *any* corn oil margarine. Of the total fatty-acid content, 28% is cis-cis linoleic acid. Thus, it can be most useful in a program for reducing serum cholesterol levels.




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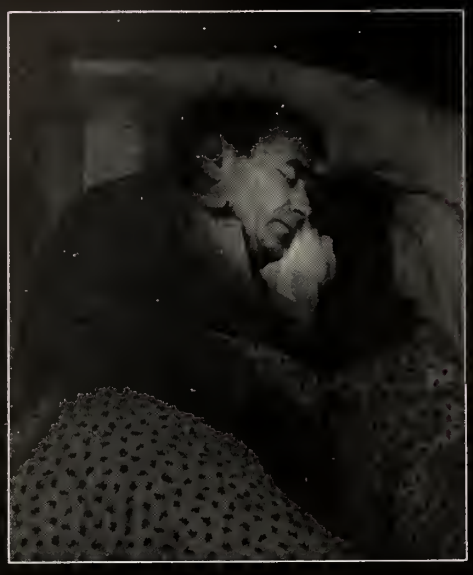



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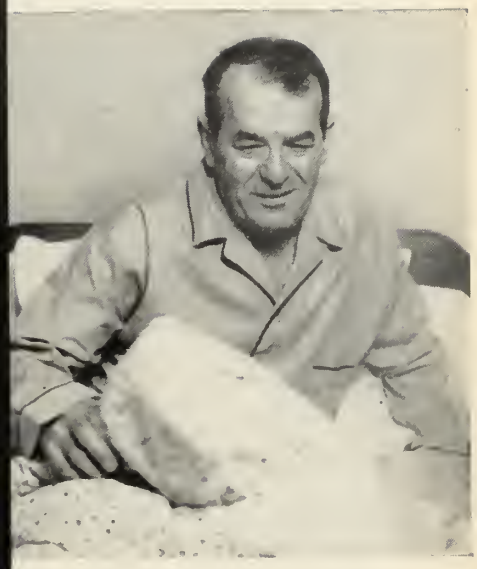


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"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

*Patients were followed for about one year.*

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*Schwartz, I. R.:
*Current Therap. Res.* 3:29, Feb., 1961.

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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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The Historian's Notebook

# The Development of Anesthesia in Ohio 1846-1961

DAVID L. FARRINGTON, M.D.,* and ROBERT A. HINGSON, M.D.**

## Part I

EVER since the discovery of the anesthetic properties of ether and chloroform, Ohio has played a significant role in the development of the specialty of anesthesia through its many contributions of pioneers, technics, machines, teaching, research and publications.

As early as 1821 newspaper accounts document the occurrence of "Ether Frolics" in Warren[1] and, once the anesthetic properties of ether were recognized, the early Ohio physicians were quick to incorporate it into their clinical practice. We do not know who first used ether in Ohio but Doctor R. D. Mussey, Professor of Surgery in the Ohio Medical College, Cincinnati, reported on the use of ether and chloroform for varied surgical procedures in *The Ohio Medical and Surgical Journal* of 1849.[2] Perhaps the first physician to use chloroform in Ohio was Doctor Daniel B. Woods of Warren. According to the *History of Trumbull and Mahoning Counties,*[3] Woods with the aid of a local druggist prepared and administered it in October of 1846. This is one year prior to its introduction by Simpson in Edinburgh, to whom chloroform's first use is credited.

The exactness of the date when Woods first administered chloroform can be seriously questioned, but his priority of use in Ohio remains. The next few years saw the widespread application of chloroform and ether for surgical and obstetrical anesthesia administered by various types of inhalers or open drop technics, and the use of the crude but effective method involving partial suffocation with nitrous oxide and air or oxygen if available.

The modern era began in 1890 when Doctor George W. Crile used atropine to block reflex cardiac irritability precipitated by manipulation of the larynx.[4] In 1897 he used cocaine to block peripheral nerves,[5] and he performed the first brachial block under direct vision.[6] Prior to the turn of the century he developed the principle of premedication with morphine and scopolamine.[7] Spinal anesthesia, in which Doctor Crile was an early pioneer, was quickly accepted and amputations were performed utilizing this method as early as 1899.[8] In 1903 he stressed the importance of the maintenance of a record of blood pressure in surgery, and in 1904 a 12 year old child, following a cardiac arrest during surgery, was resuscitated by the use of an arterial infusion of epinephrine and the administration of oxygen under positive pressure.[9] The recovery is recorded as being complete.

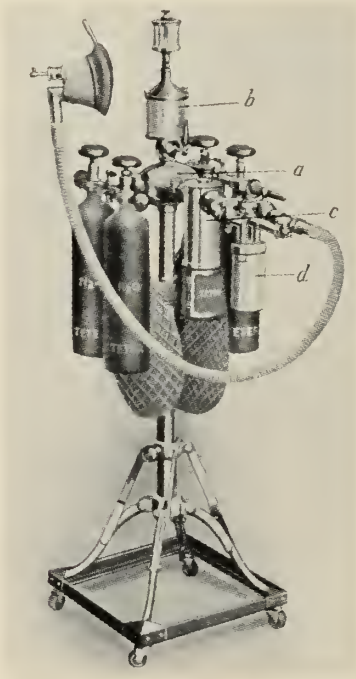



FIG. 1. *Teter Gas Machine*

In 1908 Doctor Crile proposed his theory of "anoci-association," which in effect was the first statement of the concept of balanced anesthesia.[10] He utilized

*Dr. Farrington, Willoughby, is a member of the staff, Lake County Memorial Hospital, Willoughby, Ohio.

**Dr. Hingson, Cleveland, is Professor of Anesthesia, Western Reserve University School of Medicine.

Submitted August 25, 1961.

premedication, local or spinal block and a light general anesthetic. With minor modifications this method enjoys great popularity even today. Antedating the work of Kowenhoven, Jude and Knickerbocker[11] of Johns Hopkins in 1959 by 45 years, Crile described accurately a technic of rhythmic, intermittent closed-chest cardiac massage and artificial respiration documented by case records with objective data in his text, *Anemia and Resuscitation,* published in 1914.[12]

Doctor C. K. Teter, a dentist and physician of Cleveland, developed a gas machine in 1903 which was one of the very first for the successful administration of nitrous oxide and oxygen.[13] His machine (Fig. 1) utilized a continuous flow principle with a pressure-controlled expiratory valve which enabled him to administer nitrous oxide under several millimeters



Charles K. Teter, D.D.S., M.D.



Ralph M. Waters, M. D.

of mercury pressure. With his machine Teter became an expert in the art of nitrous oxide anesthesia, building up a large dental practice as well as administering anesthesia for general surgery. He soon accumulated over 100,000 cases of its use and this wide experience brought him to the attention of Doctor Crile[14] with whom he was a pioneer in the application of nitrous oxide for general surgery. Doctor Teter was made special anesthetist at Lakeside Hospital and also the Chief of Anesthesia at the old St. Luke's Hospital in Cleveland.

Crile's response to this new technic was extremely enthusiastic, and so much nitrous oxide was used that the first hospital plant for nitrous oxide manufacture was established in the basement of the old Lakeside Hospital.[15] The gas was piped to the operating rooms, which was the first innovation of this kind in the country. Problems in the manufacture of nitrous oxide at the Lakeside plant gave rise to production methods which were soon adopted by the embryo Ohio Chemical Company for the manufacture of their commercial gas.

In 1912 Doctor Crile established the Lakeside School of Nurse Anesthetists under the able leadership of Agatha Hodgins. Of greater significance is the fact that while a second year medical student at Western Reserve, Ralph Waters observed Doctor Teter administer nitrous oxide anesthesia and was impressed sufficiently to describe this experience as one of the three influences which directed him into the field of anesthesia.[16] Doctor Waters was destined to become the dean of American anesthesiologists.

Doctor Jay A. Heidbrink, a Minneapolis dentist, purchased the first Teter gas machine that he saw. Various modifications led to the pilot model of the Heidbrink machine, and to the formation of the company which bore his name, for its manufacture.[17] This machine soon became the standard machine throughout the American hemisphere, and is still produced in a modern version by the Ohio Chemical and Surgical Equipment Company, which acquired the Heidbrink Company in 1938.

In 1910 Doctor F. J. Cotton and William Boothby of Boston visited Cleveland and studied the anesthetic technics and Teter machines used by Crile's anesthetists. They returned to Boston and soon developed an anesthetic machine[18] which was to lay the foundation for the development of the Boyle machine. This machine was standard in the British army of 1917 and it has, with minor changes, now become a standard machine used in half of the world.

The Ohio Chemical Company was established in Cleveland in the year 1910 by Justin G. Sholes and Graham W. Clarke for the purpose of manufacturing medical gases, and they marketed nitrous oxide, oxygen and carbon dioxide in black iron pipe tanks.[19] One of the founders, Mr. Clarke, redesigned the Teter gas machine, with the help of the anesthesia service of Lakeside Hospital. This model was known as the Ohio Monovalve Machine, the first member of the Ohio Chemical anesthesia machine series.

*(To Be Concluded in December Issue)*

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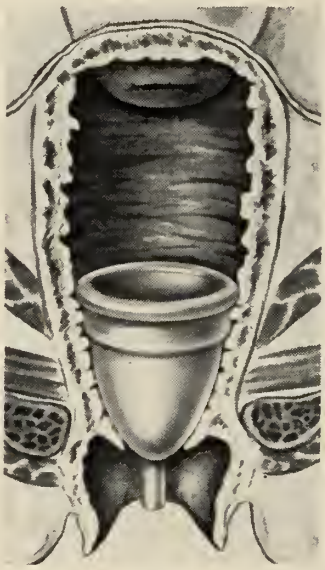
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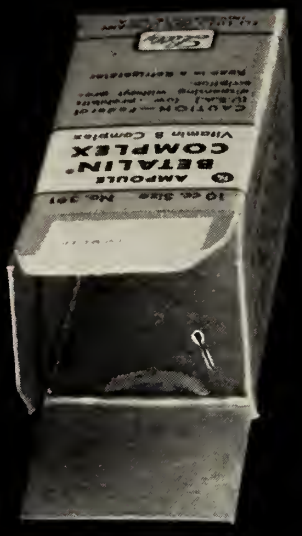
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VOL. 58 NOVEMBER, 1962 NO. 11

# Esophageal Hiatus Hernia—Abdominal Approach

CHARLES D. HAFNER, M.D., JOHN H. WYLIE, JR., M.D., and BROCK E. BRUSH, M.D.

OF the several types of hernia which occur through the diaphragm, the most common one by far is the anatomical derangement known as esophageal hiatus hernia. As many of the mysteries of the symptomatology of the upper abdomen have been unveiled by improved diagnostic and therapeutic measures in recent years, much work has been done to broaden our understanding of the physiological anatomy of the distal esophagus. This has resulted in a better understanding of the pathophysiological mechanisms responsible for the symptoms and complications associated with esophageal hiatus hernia. Anatomical dissections by Lerche[1] and others, as well as roentgenologic studies and correlations by Wolf[2] have helped clarify some of the confusion which exists with regard to the region of the distal esophagus and esophagogastric junction.

## Anatomy and Physiology

The development of the diaphragm is a complex embryological process, since various parts are derived from separate sources. The anterior, lateral, and central portions are formed from the transverse septum and fused ventral mesentery. The posterolateral portion is formed by the fusion of the dorsal mesentery and mesoderm, derived from the receding wolffian body, with the pleuroperitoneal membrane derived from the pulmonary ridge. It is most likely that the dorsal mesentery gives rise to the posterior and central portions of the diaphragm which contain the esophageal opening. The mesodermal cells from the receding wolffian body form the right and left crura of the diaphragm.

The esophageal hiatus in almost every instance is formed by the right crus of the diaphragm. The fibers of the right crus of the diaphragm intertwine to form a sling-like structure around the esophagus. This muscular sling is sometimes reinforced by fibers from the left crus of the diaphragm. The terminal

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From the Department of Surgery, Henry Ford Hospital, Detroit, Michigan.

Submitted December 19, 1961.

esophagus does not possess a true sphincter which can be dissected anatomically. However, the distal three centimeters of the esophagus does show contraction and relaxation and acts as a unit independently of the adjacent esophagus and stomach. Lerche used the term "vestibule" to designate this segment. This vestibule, however, can be demonstrated roentgenographically only in the presence of a direct, sliding hiatus hernia, since under normal conditions the distal portion of the vestibule is located in and below the diaphragm. Hence, a functional sphincteric mechanism does exist in the distal esophagus. The chief purpose of this mechanism is to prevent regurgitation of gastric contents into the esophagus.

The phrenoesophageal ligament or membrane is a thin fibroelastic structure arising from the transversalis and subserosal fascias, primarily from the infradiaphragmatic surface, but also to a lesser extent from the supradiaphragmatic surface. These fascial layers unite at the edge of the hiatus to bridge the space between the hiatus and the esophagogastric junction. Here, the fibers of this ligament pass inferiorly and superiorly, fusing with the tunica adventitia of the esophagus. Thus, it forms a flexible connection between the diaphragm and esophagogastric junction, allowing a normal range of mobility during deglutition and respirations. In this manner, the phrenoesophageal membrane stabilizes the lower esophagus and maintains the stomach inferiorly to the diaphragm.

The phrenoesophageal membrane, in addition to this, combines with the right diaphragmatic crus to maintain an acute angle at the esophagogastric junction. This acute angle at the junction of the esophagus and stomach is another important mechanism in preventing regurgitation of gastric contents into the eosphagus. It should, therefore, be noted that the right diaphragmatic crus which forms the esophageal hiatus is also important in maintaining this acute angle, and this fact should be considered in the repair of a hiatus hernia.

## Types of Hiatus Hernia

Essentially, there are two types of hiatus hernia: (1) the sliding type, and (2) the paraesophageal type. Other varieties have been described, particularly the congenitally short esophagus. However, this is a congenital anomaly and not a true herniation. It is now generally accepted that a true congenitally short esophagus is extremely rare, if it exists at all. Consequently, the majority of hiatus hernias associated with short esophagi are probably due to chronic inflammation with acquired cicatricial shortening of the distal esophagus. The sliding variety of hiatus hernia is a direct, concentric displacement of the stomach and also the esophagogastric junction through the diaphragmatic defect. This constitutes, by far, the most common variety, approximating 90 per cent of cases in some series. In contrast to this, the less common variety, the paraesophageal type, is a herniation of a portion of the stomach through the diaphragmatic defect but the esophagogastric junction remains at the level of the hiatus.

## Symptoms

In the uncomplicated esophageal hitaus hernia symptoms are caused by two main mechanisms, namely: regurgitation and mechanical pressure. Regurgitation, or reflux of acid-pepsin gastric contents because of an incompetent sphincteric mechanism, results in such disturbing symptoms as heartburn, gaseous eructation, and retrosternal distress. *True* emesis is, indeed, rare in this disease. Such symptoms caused by reflux are especially more prominent in the horizontal position after a heavy meal. However, they may occur in the vertical position with or without eating. Mechanical symptoms manifested by severe pain, dyspnea, and palpitation are frequently precipitated by lifting, stooping, straining, and similar maneuvers. Episodes of symptoms may be intermittent, and weeks or months may elapse before their recurrence. However, as the condition progresses, the symptoms become more frequent and more severe. Weight loss and anemia may be a manifestation of the patient's fear of eating as well as inability to eat without regurgitation. Complications of this disease occur as reflux esophagitis leads to ulceration and hemorrhage. This progresses to permanent stricture with severe dysphagia in the last stages of the disease. An occasional perforation of the distal esophagus has been reported associated with this problem. The majority of esophageal hitaus hernias as discovered by roentgenographic screening are asymptomatic and remain so for many years.

## Diagnosis

The diagnosis of esophageal hiatus hernia is not always an easy task. It may remain asymptomatic for long periods of time and be discovered only accidentally by x-ray. The diagnosis is usually made, however, by the characteristic clinical picture and by x-ray confirmation. Endoscopic examination is also of value in the diagnosis but is of greater service in ascertaining the magnitude of complicating disease. When symptomatic, however, the esophageal hiatus hernia is one of the greatest mimics of other diseases. It may simulate cholelithiasis, cholecystitis, coronary insufficiency, duodenal ulcer, gastric ulcer, gastric carcinoma, pancreatic disease, other conditions of the distal esophagus, gastritis, hyperacidity, thoracic tumors, and intestinal obstruction.

X-ray examination remains the best method of establishing the diagnosis. Much interest in this subject, and in the general problem of evaluating the esophagogastric junction and distal esophagus, has stimulated the radiologists to develop better techniques in demonstrating this region and better criteria for evaluating the findings. Wolf and his associates[2]

have helped to clarify some of the roentgenologic difficulties in examining this area. Figure 1 from Wolf's paper demonstrates the distal esophagus in diagrammatic fashion.

Lerche's term, "the vestibule," is applied to the terminal three centimeters of the esophagus which

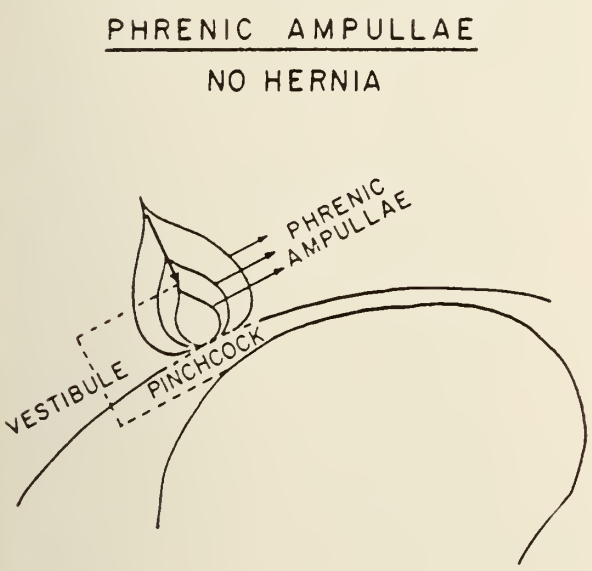



FIG. 1. *Distal esophagus, diaphragm, and stomach in diagrammatic fashion. Note variable size of Phrenic Ampullae as seen on x-ray. Vestibule cannot be seen without a hernia.*

contracts and relaxes as a unit. This vestibule, however, can be observed only in the presence of a direct, sliding type hernia, since the distal portion is located obscurely in and below the diaphragm. Figure 2 demonstrates diagrammatically the situation in which a small sliding hernia is present. Under this condition, notches or a ring may be seen at the distal margin of the vestibule indicating the junction between the vestibule and the stomach. This ring, therefore, indicates the presence of a hiatus hernia. Gastric rugae can be seen just distal to such notches on roentgen examination, indicating the presence of a herniated portion of the stomach.

The phrenic ampulla is a term introduced by Templeton[3] to apply to the sac-like collection of barium trapped above the diaphragm in deep inspiration. This is not a definite structure, however, since its variable size depends upon several factors. In a direct, sliding hernia the phrenic ampulla includes the vestibule as well as the herniated portion of the stomach. Newer techniques in roentgenologic examinations, as well as greater understanding of this area, have resulted in higher yields in the diagnosis of esophageal hiatus hernia in recent years. In fact, this diagnosis is being made in almost 10 per cent of all patients submitted for upper gastrointestinal x-rays at Henry Ford Hospital.

## Treatment

Many physicians, even at the present time, fear the magnitude of operative repair of these hernias and continue to treat a large number of symptomatic hernias medically. Frequently, this results in fairly good control of the patient's symptoms. However, this form of treatment can never cure this anatomic defect and, consequently, the majority of patients progress with their symptoms or "learn to live with" this condition.

Many authorities believe that a hiatus hernia is comparable to hernias elsewhere in the body and, therefore, should be repaired whether they are symptomatic or not. It is their belief that these hernias, as others, progress in size and in symptoms. If they are repaired early before enlargement or before complications, the surgical procedure is relatively easy, the results are long lasting, and the recurrence rate is much lower. This concept is probably correct. However, at the present time, it is our belief that only symptomatic hernias should be subjected to surgical repair.

## Abdominal Approach

Until approximately 15 years ago the abdominal approach to esophageal hitaus hernia enjoyed overwhelming popularity. This was partially due to the leadership of Stewart Harrington,[4] an outstanding clinical authority on the repair of all diaphragmatic hernias. However, as improvements in thoracic surgery progressed, the transthoracic approach gained popularity, especially under the leadership of Sweet[5] and Allison.[6] Nevertheless, during the past few years there has been a definite trend for the pendulum to swing back in heavy favor of the abdominal approach. Such men as Beardsley,[7,8] DeBakey,[9] Crawford,[9] McBurney[10] and many others[11,12] have discontinued the use of the transthoracic approach, which

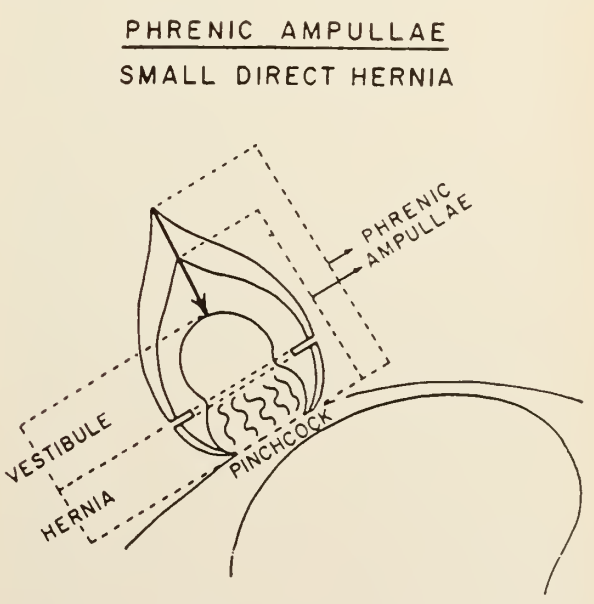



FIG. 2. *Note Vestibule, ring at esophagogastric junction, and hernia with gastric mucosa when small direct hernia is present.*

they had previously employed, in favor of the abdominal approach.

Following is a list of advantages achieved by employing the abdominal approach, which we believe are worthy of consideration:

1. Permits thorough exploration of the entire abdomen.

2. Permits adequate diagnosis of the symptom complex.

3. Less traumatic to patients, many of whom are poor risks.

   *A.* Less operative time.

   *B.* Less derangement of anatomy.

   *C.* Anesthesia and surgery better tolerated in the supine position as opposed to the lateral position used in the transthoracic approach.

4. Better postoperative course.

   *A.* Immediate.

      a. Fewer pleural complications.

      b. Better postoperative ventilation which is essential in the poor risk and older patient.

   *B.* Late.

      a. No painful thoracotomy incision.

      b. No herniation through diaphragmatic counter incision.

5. Simultaneous correction of co-existing intra-abdominal disease.

6. Better exposure for definitive gastric procedures in dealing with reflux peptic esophagitis.

Many proponents of the transthoracic route, as well as abdominal surgeons who have haphazardly approached the esophageal hiatus from below, have condemned the infradiaphragmatic approach because of inability to expose the region adequately. This condemnation is not justified. The secret to success in the transabdominal route is a *methodical approach to the problem of exposure*. If this is carried out, there is no doubt that infradiaphragmatic esophageal hiatus herniorrhaphy can be a simple, fast, nontraumatic procedure, better tolerated in the older and poor risk patient in whom the majority of these symptomatic herniations appear.

Coexisting intra-abdominal disease has been found to occur in 30 to 50 per cent of these patients depending upon individual series. It does not seem logical to subject such patients to two separate major operative procedures, when both conditions can be corrected simultaneously.

Using the transthoracic approach, herniation through a diaphragmatic counter incision is a definite possibility, and several such cases have been reported in the literature by Coppinger,[13] Boyd,[14] Johnston,[15] Keshishian,[16] and others. This catastrophe can be avoided by employing the transabodminal approach.

This procedure also affords excellent opportunity to perform the "balanced" or "combined" operation as advocated by Berman,[17] Herrington,[18] and others for reflux esophagitis.

### Technic of Transabdominal Repair

The best incision which we have found is a high, midline, epigastric incision extending superiorly along the left side of the xiphoid process to just below the umbilicus by a curved incision inferiorly. The incision should stay on the left side of the xiphoid process in order to avoid an occasional entrance into the right pleural space in the few instances in which the right pleura extends to that level. Following adequate exploration of the entire abdominal cavity, the left lobe of the liver is mobilized from its infradiaphragmatic attachment by dividing the left triangular ligament. This freed left lobe of the liver is then retracted to the right side by a padded Deaver retractor. The herniated stomach is returned into the abdominal cavity and a small amount of traction is maintained on the stomach.

The esophagus is then mobilized by inserting the forefinger of the right hand around from the left side, dissecting it bluntly from the aorta, posteriorly. As the right index finger dissects behind the esophagus, it continues to the right side where a small



FIG. 3. *Exposure during infradigaphragmatic repair of hiatus hernia.*




FIG. 4. *Preoperative Hiatus Hernia. Note large size of hiatal defect, vestibule, and ring.*

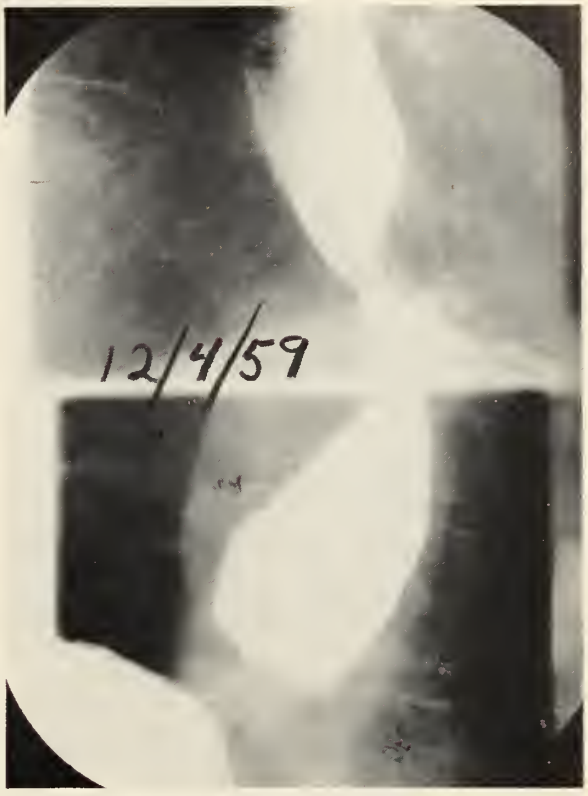



FIG. 5. *After repair of Hiatus Hernia shown in Figure 4, normal Phrenic Ampulla is seen.*

opening is made in the superior portion of the gastrohepatic ligament. A tape or rubber drain is then placed around the esophagogastric junction for further traction. The peritoneal reflection from the infradiaphragmatic surface, along with the phrenoesophageal ligament which is usually attenuated and relaxed, is then incised along the anterior and lateral portions of the esophagus for better mobilization. This allows several centimeters of the distal esophagus to be freed and brought within easy vision.

Division of the superior portion of the gastrohepatic ligament is then accomplished between clamps, and this allows better exposure of the underlying right and left crura of the esophageal hiatus. The vagal nerves should be identified and retained together with the distal esophagus in the traction tape. However, at this point we have found it profitable to replace the traction tape with a small appendix retractor or similar device, so that the *width* of the retractor gives better exposure to the underlying crura (Fig. 3). A ribbon retractor is then used to displace the lesser curvature and body of the stomach posteriorly, inferiorly, and to the left. At this point, the right and left crura of the hiatus can be further visualized by using a Kettner dissector to wipe away the remaining adipose and areolar tissue.

The right and left crura of the hiatus are then easily accessible for reapproximation with No. 1 silk sutures. Heavy silk should be used in order to facilitate approximation of the muscular structures without cutting through the tissues. The first suture should be placed at the apex posteriorly. After this suture is placed, traction on it easily facilitates the placement of the remaining sutures. The hiatus should be closed to a diameter which admits the esophagus, a Levin tube, and the tip of the index finger with ease. If the tip of the index finger fits too snugly, the patient will complain of postoperative dysphagia; therefore, we believe that much care should be exercised in deciding the correct size of the new hiatus.

The phrenoesophageal ligament is reattached to the infradiaphragmatic surface with interrupted sutures of No. 000 silk. This is an important step, since this structure maintains the relative position of the esophagogastric junction to the newly formed hiatus. The crura of the hiatus should always be approximated behind the esophagus, at least whenever possible, since recurrence is likely to occur in the posterior portion. In addition to this, posterior closure also helps to restore the normal angulation of the esophagogastric junction which helps to prevent gastric reflux. However, in the event that a large defect prohibits complete closure posteriorly, then partial closure may be accomplished anteriorly.

Complications of esophageal hiatus hernia present additional surgical problems. For the treatment of reflux peptic esophagitis which is reversible and not involved with a great degree of stricture or shortening, any one of several procedures can be carried

out. These include vagotomy with gastroenterostomy, vagotomy with pyloroplasty, and subtotal distal gastrectomy with vagotomy. If irreversible stricture formation and shortening of the esophagus has resulted from progression of the disease process, esophagogastrectomy with pyloroplasty, Roux-Y esophagojejunostomy, or similar procedure may be necessary. However, it is generally agreed that resection of the esophagus should be avoided if at all possible. This is only rarely necessary since the majority of cases are not so severely involved, and even some of the far advanced cases are reversible after adequate treatment of the underlying problem.

## Analysis of Cases

To the present time, only certain patients have been selected for repair of hiatus hernia via the transabdominal approach. Consequently, during the period of one year, only 11 such procedures have been performed on this surgical service. No statistical study is intended on such a series at this time. The patients selected for this procedure were mainly those with associated intra-abdominal disease or those with a difficult abdominal symptom complex. In all cases, the hiatus hernia was demonstrated preoperatively by x-ray and considered symptomatic by clinical history.

Table 1 summarizes our experience with these 11 cases. The average age was 53 years, the youngest being 27 and the oldest 69. There were six women and five men. Four large, five medium, and two small hernias were repaired. The defect was considered large if 5 fingers or more could be inserted into the hiatus. If 3 to 4 fingers could be inserted, the defect was considered medium, while 2 fingers was considered to be a small hernia.

Eight patients had associated chronic gallbladder disease. Three patients had diverticulosis in addition to chronic cholecystitis with cholelithiasis, thus fulfilling the requirements for Saint's triad.[19] One patient was operated upon for an asymptomatic gastric polyp coexisting with a symptomatic hiatus hernia.

One patient, a 27 year old man, had had two previous biliary tract procedures elsewhere without relief of his symptoms. A third procedure for his bile ducts and pancreas was advised at another hospital. Exploration of these areas revealed no abnormalities, and repair of his hiatus hernia gave complete relief of his symptoms.

TABLE 1. *Esophageal Hiatus Hernia—Abdominal Approach.*

| Patients | Age | Sex | Size of Hernia | Associated Pathology | Results |
|---|---|---|---|---|---|
| 1 | 69 | F | Large | Cholecystitis, Diverticulosis | Recurrence (7 months) |
| 2 | 44 | M | Small | Cholecystitis | Excellent |
| 3 | 27 | M | Medium | None | Excellent |
| 4 | 66 | F | Large | Cholecystitis, Diverticulosis | Excellent |
| 5 | 51 | M | Small | None | Excellent |
| 6 | 66 | F | Large | Cholecystitis, Diverticulosis | Excellent |
| 7 | 41 | F | Medium | Cholecystitis | Excellent |
| 8 | 56 | F | Large | Cholecystitis | Excellent |
| 9 | 47 | F | Medium | Cholecystitis | Excellent |
| 10 | 66 | M | Medium | Gastric Polyp | Excellent |
| 11 | 46 | M | Medium | Cholecystitis | Excellent |

## Results

Length of follow-up prevents any conclusions at this time. Evaluation of early results was based upon relief of clinical symptoms which were attributed to the hiatus hernia and correction of the anatomical defect as measured by pre- and postoperative roentgenology. All 11 patients obtained relief of symptoms; however, one patient developed a recurrence of hernia, which was demonstrated by x-ray seven months later. Therefore, results were considered excellent in 10 patients ranging from 9 to 26 months postoperatively.

Anatomic correction of hiatus hernia as visualized by roentgenographic means can be seen in Figures 4-7.

## Summary

Some of the pertinent anatomy, physiology, and pathology concerned with esophageal hiatus hernia have been stressed. The important points in x-ray



FIG. 6. *Hiatus Hernia showing vestibule, ring, gastric mucosa and wrinkling of esophagus.*



FIG. 7. *Postoperative films of patient shown in Figure 6. Normal Phrenic Ampulla is seen.*

diagnosis as pointed out by Wolf *et al.* have been re-emphasized.

It is important to recognize the various symptom complexes of hiatus hernia in order that these may be differentiated from other disease entities. This will undoubtedly prevent multiple operative procedures on the same patient. Nothing is more disconcerting than to have persistence of symptoms following the removal of an asymptomatic diseased gallbladder.

There are many proponents of both the thoracic and the abdominal approach in the repair of a hiatus hernia. To advocate one approach to the complete exclusion of the other would be folly. Certainly, there is a place for each technique. However, we feel that in the average case, the abdominal approach offers several advantages as previously enumerated. This is especially true when a co-existing intra-abdominal disease or confusing symptom complex is present.

We believe that the abdominal approach is a fast, atraumatic, and relatively simple procedure to perform, if proper attention is paid to the methodical exposure and dissection of the operative site. It is well recognized that some surgeons will on occasion place a blind, poorly directed, "suture to snug up an enlarged esophageal hiatus." We in no way consider this a repair of a hiatus hernia, and this practice should be condemned.

An initial report is made on 11 patients most of whom had co-existing intraabdominal disease. Early follow-ups reveal 10 excellent results as measured by relief of symptoms attributed to the hernia and by x-ray evidence postoperatviely.

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FLUORIDE AND TOOTH DECAY — Results of a 14-year study provided evidence that either prenatal or postnatal ingestion of fluoride reduces the incidence of caries, but the combination of prenatal and postnatal ingestion is even more effective. It is important that prenatal ingestion be begun during the first two trimesters of pregnancy.

All subjects receiving fluoride were put on the same dosage, whether they were gravid women or children up to 8 years of age. They were given single daily doses of one of the following: 1 mg. fluorine ion from CaF2, 1.2 mg. fluorine ion from NaF, or 0.825 mg. fluorine ion from $Na_2PO_3F$. Each product was in the form of tablets, which were either dissolved in the mouth, dissolved in a liquid before ingestion, or chewed. The study was done in unselected patients coming to the hospital from all walks of life and all ethnic groups. The water in the study area is free of fluoride.

The finding that tooth eruption is delayed (sometimes as long as a year) in fluoride-treated cases may be a factor in the lower incidence of decay. Teeth delayed in eruption can mature more before being exposed to the forces that trigger the caries mechanism. — ABSTRACT: Reuben Feltman, and George Kosel: Prenatal and Postnatal Ingestion of Fluorides — Fourteen Years of Investigation. *Journal of Dental Medicine*. 16:190-198 (October) 1961.

# Congenital Atresia of the Esophagus With Tracheo-Esophageal Fistula

## Presentation of Five Cases

RICHARD C. SINGERMAN, M.D., and ALEJANDRO M. BERBA, M.D.

CONGENITAL atresia of the esophagus with tracheo-esophageal fistula is not a common clinical entity. Humphreys[1] et al. in 1956 reported an incidence of 1 in 3000 births at the Sloane Maternity Hospital and Haight[1] in 1957 gave a figure of 1 in 4447 births at Washtenaw County, Michigan. At Lakewood Hospital, which is a 272 bed hospital, there were five cases of congenital atresia of the esophagus with tracheo-esophageal fistula and two cases of congenital atresia of the esophagus without an associated tracheo-esophageal fistula in a 16 year period (1944-60). During this period there were 30,983 live births at Lakewood Hospital giving an incidence of 1 in 6196 live births for this rare congenital anomaly. The five cases of combined defects are presented.

### Case Reports

**Case No. 1. February, 1944:** This newborn white male infant of 32 weeks gestation weighed 5 lbs. 8½ oz. at birth. The mother was 29 years old, gravida II, Para I. Pregnancy was uneventful, and the child was delivered spontaneously as a breech presentation.

No gross abnormalities were noted at birth. However, considerable mucus was noted in the throat and aspiration was required at times. Cyanosis was observed now and then. The baby was placed in an incubator. It was observed that he vomited every feeding. Progressive jaundice and weight loss occurred. On the eighth day, he developed convulsions and spastic contracture of the body and died. No surgery was performed.

*Autopsy Findings:* The final anatomic diagnoses included: Massive hemorrhage about the base of the brain and cerebellum and into all the ventricles with wide dilatation of the lateral and fourth ventricles; congenital complete atresia of the upper esophagus with lower esophagus and trachea communicating; bronchopneumonia, massive, bilateral; dehydration; icterus.

**Case No. 2. June, 1955:** This full term white male infant weighed 5 lbs. 15 oz. at birth. The mother was 24 years old, gravida IV, Para III. The mother received propylthiouracil during pregnancy.

Aspiration of mucus from the infant's throat was frequently necessary. There was bilateral enlargement of the thyroid gland. X-ray studies were made and showed complete atresia of the middle third of the esophagus with fistula between the tracheobronchial tract and the lower third of the esophagus. The infant was transferred to another hospital where surgery was performed. However, he died on the third postoperative day.

**Case No. 3. January, 1959:** This newborn baby girl of 33 weeks gestation weighed 3 lbs. 8 oz. at birth. The mother was 26 years old, gravida II, Para I. Her pregnancy was uneventful until the day of admission when she had vaginal bleeding. The diagnosis was premature separation of the placenta. However, delivery was spontaneous and easy.

The baby appeared normal on examination and was placed in an incubator. Cyanosis was noted at times, and considerable mucus was aspirated from the nose and throat. Regurgitation of feeding was observed and, because of this, x-rays were taken. These were interpreted as congenital stenosis of the esophagus with a tracheo-esophageal fistula. She was taken to surgery approximately 48 hours after birth.

*Operative Findings:* A right thoracotomy incision was made. The distal end of the esophagus ended in the right lateral aspect of the trachea. This was detached and the defect in the trachea was closed. Both ends of the esophagus were then carefully dissected and anastomosed over a catheter inserted through the nose to the stomach. A thoracotomy tube was left in the thorax. Twenty-five cubic centimeters of whole blood was given during the surgery. This child tolerated the procedure fairly well.

*Postoperative Course:* The child did not fare very well postoperatively. Respiratory irregularity and cyanosis were noted and she died on the second postoperative day.

*Autopsy Findings:* The site of anastomosis was intact. The final anatomic diagnoses included: Recent repair of esophageal atresia and tracheo-esophageal fistula; bronchopneumonia; prematurity; partial atelectasis of lungs; fatty metamorphosis of the liver.

**Case No. 4. November, 1959:** This newborn white female infant of 36 weeks gestation weighed 5 lbs. 9 oz. at birth. The mother was 31 years old, gravida I, Para 0. Her pregnancy was uneventful and the delivery by low forceps was described as easy.

The infant's color was described as good, and no gross abnormalities were noted. However, much thick mucus was observed in the throat, and this was aspirated now and then. The baby was placed in an incubator. The color was noted to be dusky at times, and frothing of the mouth and nose was likewise reported. Because of these observa-

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tions, x-rays were taken. These were interpreted as esophageal atresia with a fistulous communication between the bronchi and the lower portion of the esophagus. The baby was brought to surgery approximately 24 hours after birth.

*Operative Findings:* A right thoracotomy incision was made, and a large esophageal pouch was found extending down to the level of the azygos vein. The lower esophageal remnant was found attached to the trachea just above the bifurcation. This was detached, and the hole in the trachea was repaired. After careful dissection, the proximal and distal ends of the esophagus were anastomosed over a catheter inserted through the nose to the stomach. A thoracotomy tube was placed in the thorax. Fifty cubic centimeters of whole blood was given during the surgery. The infant tolerated the operation fairly well.

*Postoperative Course:* She had a good postoperative course as a whole. The thoracotomy tube and the Levin tube were removed on the first postoperative day. Feeding was begun on the second postoperative day starting with Karo water which was well tolerated. However, on the third postoperative day, respiration was noted to be irregular and grunting. Chest x-ray was taken and revealed tension pneumothorax on the right with atelectasis of the right lung. This was relieved by reinsertion of thoracotomy tube. Thereafter, recovery was uneventful. The thoracotomy tube was removed on the seventh postoperative day. Follow up x-rays of the esophagus later showed minimal constriction at the site of anastomosis but no obstruction. The child had a slight cough on discharge, 16 days after surgery. It weighed 5 lbs. 8 oz. She is now doing well at age 2 years except for a persistent, brassy cough.

**Case No. 5. March, 1960:** This white baby girl of 39 weeks gestation weighed 6 lbs. 7 oz. at birth. The mother was 24 years old, gravida II, Para I. Her pregnancy was uneventful and the delivery was described as average.

No gross abnormalities noted at birth. However, she developed regurgitation during feeding. Because of this, x-rays were taken. These revealed atresia of the mid-esophagus with a communication between the trachea and the lower esophageal segment. The patient was brought to surgery approximately 72 hours after birth.

*Operative Findings:* A right thoracotomy incision was made. The blind upper esophageal pouch, which was connected by an atretic segment to the lower esophageal segment, was easily visualized. The connection between the trachea and the lower segment of the esophagus was likewise identified. This was detached, and the defect in the trachea was repaired. The distal and proximal ends of the esophagus were then dissected free and the atretic segment was excised. End-to-end anastomosis was made over a catheter inserted through the nose to the stomach. A thoracotomy tube was left in the thorax. The baby tolerated the procedure fairly well and received 45 ccs of whole blood during the surgery.

*Postoperative Course:* The child did very well during the early part of the postoperative period. The thoracotomy tube and the Levin tube were removed on the second postoperative day. Feeding was started on the third postoperative day. However, the infant developed respiratory distress for which an x-ray was ordered and this showed pleural exudate in the right chest. Thoracentesis was done and air and thick serous material were withdrawn. She was brought back to surgery on the fifth postoperative day, where a chest tube was again inserted and a plastic tube was put into the stomach through the esophagoscope. She improved partially but upon irrigation of the thoracotomy tube, white material came out. Feeding was stopped and fluids were given parenterally. X-rays at this juncture showed disruption of the anastomosis with a fistulous communication between the upper esophagus and the right pleural space.

On the eighth postoperative day, gastrostomy was performed. The baby developed cough. Drainage from the tube continued to be white. The infant was noted to be dusky now and then, and oxygen had to be given on several occasions. Gastrostomy feeding was continued. Antibiotics were given. The chest tube came out 16 days after it was put in. Repeat x-rays about a month from the initial surgery showed reestablishment of the continuity of the esophagus. The gastrostomy tube was removed 27 days after it was inserted. Oral feeding was started before removal of the gastrostomy tube, and this was well tolerated. Follow-up x-rays later showed marked constriction at the anastomotic site with dilatation of the proximal segment. The child was brought back to surgery approximately two months after the original operation wtih the intent of excising the stenotic area and doing an end-to-end anastomosis. This was done together with gastrostomy. However, the child did poorly after the surgery and never recovered. She died 10 hours after the operation.

*Autopsy Findings:* The anastomosis was intact. The final anatomic diagnoses included: Recent repair of congenital atresia of the esophagus with tracheo-esophageal fistula; bronchopneumonia, bilateral; organizing acute mediastinitis; fatty metamorphosis of the liver.

## Discussion

Congenital atresia of the esophagus can occur alone, but usually (86.5 per cent in Haight's[1] series) there is a concomitant tracheoesophageal fistula. In all probability, this anomaly occurs between the end of the third and the sixth week of embryonic life. Other congenital abnormalities may be associated with this condition and affect the prognosis. DeBoer and Potts[2] reported 9.6 per cent of their patients had associated cardiovascular anomalies and 6.2 per cent had renal and gastrointestinal anomalies. Haight[1] noted 28 per cent of his patients had significant anomalies and 72 per cent had none.

Newborn babies who choke and breathe poorly and in whom excessive secretion is noted in the nose and throat and those who always cough or regurgitate immediately after feeding, should alert one to this type of congenital anomaly. The diagnosis is usually clinched by the roentgenologic findings.

Operative treatment varies but the aim is always to restore the continuity of the esophagus either by direct end-to-end anastomosis or by small or large bowel transplantation and to close the defect in the respiratory tree. The postoperative care and management of these patients demands careful and frequent observations. Great care must be taken when feeding them in order to avoid regurgitation and thereby to minimize or prevent pulmonary complications.

The mortality rate is still high, but it is going down. This can be attributed to early diagnosis, good anesthesia, and better surgical techniques. Without prompt surgical intervention, the mortality rate is certainly 100 per cent. Morbidity and mortality are influenced a great deal by the age of gestation and the weight of the child at birth and at admission. DeBoer and Potts[2] in 1957 reported an average mortality of 50.4 per cent in 113 patients during a 10 year period.

## Summary

Five cases of congenital atresia of the esophagus with tracheo-esophageal fistula are presented. Four were operated upon, and only one survived the surgery. The lone survivor is two years old now and is doing well.

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# Congenital Esophageal Atresia

## A Report of Improved Survival of Infants through Prompt Recognition and Surgical Correction

JOHN P. MINTON, M. D., and H. WILLIAM CLATWORTHY, Jr., M. D.

IMPROVED surgical management of congenital atresia of the esophagus with or without tracheo-esophageal fistula has produced most gratifying results. Survival rates in 967 cases reported in the past five years varied from 36 to 67 per cent with a mean survival of 52 per cent. (Table 1.) At the Columbus Children's Hospital almost three fourths of the infants admitted with this disease survive. This high survival rate can be accomplished only through the cooperation of the surrounding newborn nursery personnel and the referring physicians, who have established the diagnosis early and arranged for the safe transit of the infant. This paper reports our experience with the 49 infants born with esophageal atresia who were admitted to this hospital between July, 1954 and July, 1960.

TABLE 1. *These figures represent the survival percentage of individual hospital series according to the year published. Of a total of 967 patients there is a mean survival rate of 52 per cent.*

| Author | No. of Patients | Survival |
|---|---|---|
| Humphreys, et al. *Journal Thoracic Surgery*, 1956 | 88 | 36% |
| Sundegaard *Arch. Dis. Child.*, 1957 | 105 | 56% |
| Haight *Journal Thoracic Surgery*, 1957 | 200 | 54% |
| Roberts *Thorax*, 1958 | 36 | 50% |
| Gertz & W. Smith *Danish Medical Bull.*, 1958 | 67 | 42% |
| Hellings, et al. *Lancet*, 1958 | 54 | 56% |
| Jacobs & Papper *New York State J. Med.*, 1959 | 72 | 57% |
| Rehbein & Yanagiswa *Arch. Dis. Child.*, 1959 | 84 | 46% |
| Morrison *Ann. Otol., Rhin. & Laryng.*, 1959 | 109 | 40% |
| Potts & Idriss *Maryland M. J.*, 1960 | 104 | 67% |
| Minton & Clatworthy, 1962 | 48 | 73% |
| Total | 967 | Mean Rate 52% |

### Diagnosis

Polyhydramnios (amniotic fluid in excess of 1500 cc.) is the earliest evidence that a newly born infant may have atresia of the esophagus in 15 to 25 per cent of the cases.[8] The usual signs are excessive salivation due to the inability to swallow secretions, choking spells, and recurring cyanosis. Attempted feedings usually produce immediate regurgitation associated with a severe choking episode, which can be relieved only by oropharyngeal suctioning. If a large fistula is present, acute abdominal distention may be noted.

An infant with any of the above symptoms should be clinically evaluated immediately. An effort to pass a stiff, new, 8-F or 10-F urethral catheter into the stomach should be made. In the presence of atresia of the esophagus an obstruction is usually felt after 12 or 15 cm. of the catheter has been inserted. Coiling of the catheter (particularly if it is pliable) in a large esophageal pouch can occur. Unless acid containing gastric content can be aspirated freely, immediate posteroanterior and lateral radiographs should be obtained to determine the position of the catheter. A tiny amount (0.5 - 1 cc.) of water soluble contrast material may be injected into the catheter if the radiologist desires to demonstrate the pouch (Fig. 1). A gas pattern below the diaphragm will indicate that a tracheo-esophageal fistula is present. No further diagnostic studies are necessary.

Following the establishment of the diagnosis by these simple maneuvers, arrangements for further care or for the safe transfer of the infant to a children's care center should be made by telephone. While in transit the infant should be accompanied by a person qualified to maintain the upper airway free of excessive mucus by repeated hypopharyngeal suctioning. Oxygen should be available and, if possible, a transit incubator should be used to maintain the

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infant at a normothermic state. X-rays and pertinent records should accompany the infant.

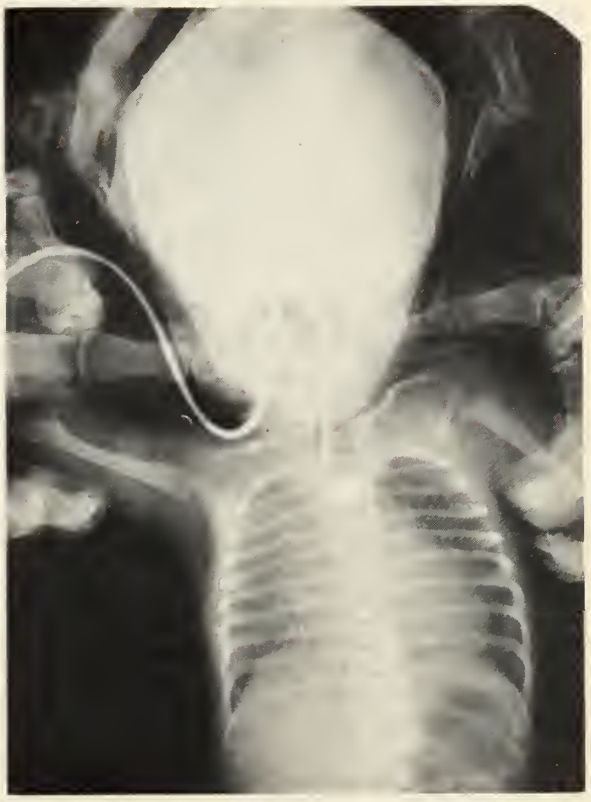
Avoiding delay in diagnosis and transit is most desirable since the most common cause of failure in the treatment of these infants is aspiration or regurgitant pneumonia.[1,2] This is a progressive problem, best avoided by early and expeditious management.

## Management of Cases

Upon arrival at the emergency room the infant is met by a member of the house staff. If additional radiographic studies are needed these are obtained immediately unless emergency supportive treatment is indicated. The infant is then transferred to a "clean" surgical nursery, which is staffed by physicians and nursing personnel who are acquainted with the multitude of problems each of these patients presents. A humidified incubator provides a stable environment, which protects the infant from exposure to infection yet does not interfere with continuous observation and repeated oropharyngeal suctioning. A multiholed suction catheter is placed into the esophageal pouch and attached to an infant suction apparatus, which will minimize the need for repeated suctioning. Infants who are dehydrated or hypovolemic require preoperative intravenous fluids. This is easily achieved by a "cut-down" in the saphenous vein which will also serve during the operative procedure. Intravenous vitamin K (1 mg. Mephyton®) and antibiotics, usually penicillin (25,000 units intravenously per pound per day) and streptomycin (25 mg. intramuscularly per pound per day), are administered on admission. Laboratory studies are limited to a hemogram, blood typing, and a urinalysis. Since in most instances the infants arrive within the first two days of life and have had no abnormal fluid losses, extensive chemical studies are unnecessary.

Surgery is performed shortly after admission in the majority of cases, within 12 hours in almost every instance. In our hands, the ideal premedication consists of 0.1 mg. of atropine only. The anesthesia, administered via the endotracheal route, is cyclopropane and oxygen.

In the rare infant in whom gastrointestinal gas is not seen on the abdominal x-rays, it is assumed that a tracheo-esophageal fistula is not present (Fig. 2). Under such circumstances the surgeon performs a cervical esophagostomy and a gastrostomy as a primary procedure. For all other patients every effort is made to divide and close the tracheo-esophageal fistula and perform an end-to-end anastomosis of the blind esophageal pouch and the distal esophageal segment. Many authors report that primary anastomosis is impossible in 10 to 20 per cent[4,5] of the infants they manage. In our experience, however, only rarely have we found the two esophageal segments so widely separated that an anastomosis is impossible, although on occasion it has been necessary to do the anastomosis under tension. In this series



A



B

FIG. 1 A & B. *Contrast filled upper esophageal pouch and the abdominal gas pattern indicating a communication between the lower esophagus and trachea.*



FIG. 2. *Well defined upper esophageal pouch and the absence of air in the abdomen. This usually indicates no tracheo-esophageal fistula. The lower esophageal segment is frequently very short in these infants.*

only two of the 48 infants did not have a primary anastomosis.

Since we routinely perform the thoracic exploration by the extrapleural route, partial breakdown or leakage from the site of anastomosis due to tension has seldom been a fatal complication (Fig. 4). Surgeons who prefer the transpleural route have not always been so fortunate, and leakage at the suture line into the pleural cavity has often been associated with mortality.[3, 6]

After a satisfactory esophageal repair has been completed, a simple Stamm type gastrostomy is performed for alimentary tract decompression and temporary feeding purposes while the esophageal anastomosis is healing. Normally, infants can swallow their saliva satisfactorily within one week after the operation.

BIRTH WEIGHT

| Weight in Gms. | No. Cases | % Survival |
|---|---|---|
| 1000 - 1500 | 2 | 0 |
| 1500 - 2000 | 3 | 66 |
| 2000 - 2500 | 16 | 68 |
| Over 2500 | 27 | 88 |

FIG. 3. *This chart indicates the relative survival percentage according to weight at birth.*

For the occasional patients in whom an anastomosis is impossible because the distal esophageal segment is absent or because it is too short, a colonic segment can be mobilized to replace the absent esophagus by anastomosing the cervical esophagus to the colonic segment and the lower end of the segment to the stomach. This is usually completed by two years of age.[5, 7]

## Summary of Cases

Between July, 1954 and July, 1960, 49 infants were admitted to The Columbus Children's Hospital for management of their congenital esophageal atresia. Thirty-seven of the 49 infants are living one and one-half or more years after discharge from the hospital. Only one infant died before an attempt at surgical correction was performed. This infant is not included in the operative survival statistics.

Fifteen of the remaining 48 surgically treated infants had other anomalies, some of which required immediate surgical attention. Others were repaired later and several were not correctable. A group with obvious lesions included: three with imperforate anus, two with congenital absence of the radius, one with lumbar myelomeningocele, and one with duodenal atresia and laryngeal stenosis. All of these survived the correction of their esophageal atresia and their associated anomaly. A mongoloid required no further surgery. In addition to these eight there were seven infants with anomalies inconsistent with further existence, including two with agenesis of one kidney and hypoplasia of the other; two with bilateral hydronephrotic kidneys; one with a diaphragmatic hernia; and two with multiple anomalies of the heart, gastrointestional tract, and genitourinary system. All of these died.

In addition to the difficulties associated with multiple anomalies, prematurity had an effect on survival (Fig. 3). In this group, 9 of the 19 infants who weighed less than 2500 grams did not survive. None survived who weighed less than 1500 grams.

## Complications

The most common finding at autopsy following surgical treatment of the infants in our series was

CAUSE OF DEATH 13 CASES

| | |
|---|---|
| Pneumonitis & Birth Wgt. 2000 Gms. | 4 |
| " & Renal Disease | 4 |
| " & Suture Line Leak | 1 |
| " & Heart, GI. & GU. Anomalies | 1 |
| " & Diaphragmatic Hernia | 1 |
| " | 1 |
| Meningitis | 1 |

FIG. 4. *Summary of the causes of death associated with this series of infants.*

severe pneumonia (Fig. 4). Sixteen of the infants had marked clinical and x-ray evidence of pneumonitis at the time of admission, and almost every infant had some transient pneumonitis during his hospitalization. However, with persistent tracheopharyngeal aspiration, antibiotics, humidified oxygen, and constant attendance to eliminate recurrent aspiration before and after the esophageal repair, only 12 infants died with pneumonitis. Pneumonitis alone accounted for only one infant's death (Fig. 4). In general, the treatment of infants with pneumonitis accompanied by prematurity and/or severe uncorrectable congenital malformation resulted in disappointment.

Postoperative esophageal stricture requiring one or more hospitalizations for dilatation occurred in 13 of the 37 currently living children. The total incidence of strictures in all surgically corrected infants was about 50 per cent. This material is currently being studied at The Columbus Children's Hospital and will be published in the future. The infants who developed a stricture began to experience difficulty with swallowing at variable periods of time after surgery. X-ray studies may demonstrate a persistent enlargement of the proximal esophageal pouch and marked narrowing at the suture line. Although routine dilatation of esophageal stricture is not carried out on the basis of x-ray appearance, the combination of x-ray evidence of a severe stricture and difficulty with swallowing has led us to undertake occasional dilatations early in the postoperative period. These dilatations are most safely and conveniently accomplished in a retrograde fashion using a Tucker type dilator and an 0 silk string which remains in the esophagus between dilatations. For infants who require only an occasional dilatation, a fine radiopaque woven urethral filiform and following dilators which can be carefully controlled under fluoroscopy may serve very well. If, during the course of three to six months, the child's esophageal stricture remains clinically significant, re-operation is now recommended. This was carried out in four cases. The operation was simply performed, and the new anastomosis has functioned satisfactorily.

In only one instance was early re-operation necessary to relieve a 2 week old infant's inability to manage his saliva. The subsequent re-anastomosis completely relieved the obstruction.

Esophago-cutaneous fistula occurred in three infants. Two of the three fistulas closed spontaneously. The third infant died within the first postoperative week, probably from his pre-existing pneumonia.

## Summary

The early diagnosis of atresia of the esophagus with or without tracheo-esophageal fistula is of paramount importance. Physicians and nurses who attend the newborn child should be aware of the early symptomatology of this potentially fatal but readily treatable anomaly. Although prematurity and multiple associated anomalies preclude survival in some infants, a 73 per cent survival rate in the 48 infants surgically corrected at The Columbus Children's Hospital during the past five years demonstrates clearly that many lives can be saved through the cooperative effort of physicians and nursery personnel in an adequately equipped neonatal surgical center.

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**PAIN IN ACUTE POLIOMYELITIS.** — Protamide, a modified proteolytic enzyme, has been investigated in 33 cases of acute poliomyelitis for its therapeutic efficacy to control pain. The drug (1.3 ml.) was administered intramuscularly every four hours as necessary and was continued for three to six days or until complete relief was obtained. Good to excellent results were obtained in 28 (84 per cent) patients and no untoward effects were noted in any patient regardless of the extent of involvement of the spinal or bulbar areas.

Although the exact mechanism of the action of the drug is not clear, relieving the inflammatory edema of the nerve trunks is a strong possibility. —G. J. Boines, M. D., Wilmington, Del.: Pain in Acute Poliomyelitis: Control with Protamide. *Delaware Medical Journal,* 32:249-250, June, 1960.

# Use of Blood Volume Determination

## Its Value in Preparation of Chronically Ill Patients for Major Surgery*

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THE chronically ill, debilitated patient who will require surgery has changes in the plasma volume and red blood cell mass that must be defined and corrected prior to the induction of anesthesia. Hemoglobin or hematocrit values are not a reliable index of blood volume and give no information about the plasma and cell compartments. If the patient is obese, aged, emaciated, or anemic, the results are often more abnormal and are always of greater importance.[2, 14]

### Material and Methods

Among the author's patients at one hospital during one year period, all of those on whom a blood volume determination was ordered, were reviewed. The resulting data are presented to illustrate the type and degree of abnormality in blood volume found in chronically ill patients, who require major surgical procedures.

The cases, with age, sex, weight, diagnosis, and surgical procedure, are shown in Table 1. The blood volume data on these 13 patients are shown in Table 2. The mean of the theoretical normal value for each determination was taken and the percentage difference between the actual value and the theoretical value determined. These percentage figures are shown in Table 3.

### Results

Note that in every instance, except one, the plasma volume was in relative excess to the red blood cell mass, when compared to theoretical normal values. In a few instances the difference was minor, but in most cases the plasma-red blood cell imbalance was marked. *Whole blood is contraindicated in replacement of blood volume in such patients.* The danger of overexpansion of the plasma space with resultant pulmonary edema is obvious. Also, after blood replacement in such patients, additional time must be allowed preoperatively for diuresis to occur.

Ten of the 13 patients had an admission hemoglobin value of 12.0 Gm. per 100 ml., or above. Despite this "safe" range of hemoglobin, 4 of these 10 patients had a 20 per cent deficit in circulating red blood cell mass, and two patients (No. 2 and No. 3) had dangerous excesses of plasma volume. Thus, in the severely ill or debilitated patient, the admission hemoglobin often reflects a combination of *hemoconcentration* (from dehydration), *anemia* (from bleeding or sepsis), and *plasma excess* (a homeostatic mechanism in chronic anemia), which may result in a normal value by cancelling opposite vectors but which in no way reflects the quality or quantity of the blood volume.

Four of the patients illustrate particular problems in blood volume analysis and are presented in greater detail.

### Case Reports

Case No. 12: This patient, a 42 year old man, was admitted because of melena and syncope. The history included indigestion of increasing severity for nine months followed by massive melena beginning 36 hours before admission. Shortly after admission the patient developed profound shock and became semicomatose. Massive replacement of blood was begun at admission and continued until the hemorrhage ceased on the third hospital day. About six hours after admission, the blood volume study was reported to show 750 cc. of red blood cells in the patient's body and, more importantly, a plasma volume that was nearly normal! This finding was interpreted as evidence that the patient had had considerable chronic blood loss preceding the massive episode. Subsequently, a more accurate history confirmed this interpretation. In view of the shock and urgent need for blood, it is almost without question that overtransfusion of whole blood would have resulted in pulmonary edema and death. With the warning of the volume study, packed cells and more judicious timing were utilized to advantage. The repeat study six days later showed the imbalance persisting but to a lesser degree. The diagnosis of duodenal ulcer was confirmed by a gastrointestinal series.

The patient was released and readmitted for an elective gastric resection one month later. A repeat blood volume

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at that time showed evidence of further occult blood loss which required packed cell replacement before surgery. The operative procedure, convalescence, and postoperative follow-up (6 month) were uneventful.

Case No. 11: The patient was a 48 year old Italian woman admitted for jaundice, chills, and fever. She had been jaundiced in Italy two years previously and had been chronically ill since that time. Pruritis had become severe two months before admission, and the acute symptoms had recurred two weeks previously.

The patient's appearance, with sunken cheeks, hollow eyes, lax skin, and deep jaundice, indicated severe cachexia. There was an abdominal mass, which descended with the liver on respiration. The preoperative investigation disclosed only evidence of obstructive jaundice and an abdominal mass. The total blood volume was slightly greater than normal despite an hematocrit of 31 per cent, but it was composed of an excess in plasma (30%) and deficit of red cell mass (30%). Correction was obtained with packed red cells and adequate time permitted for water diuresis.

At surgical exploration, the patient was found to have a large intrahepatic cyst, which was multiloculated and composed of bile duct epithelium supported by a fibrous stroma densely infiltrated with chronic inflammatory cells. A plug of this tissue had obstructed the common bile duct. The obstruction was removed at surgery and a bypass constructed from the cyst using jejunum in a Roux-en-Y anastomosis. The postoperative course was complicated by cholangitis, which responded to antibiotics. The patient has subsequently regained normal weight and is free of jaundice and gastrointestinal symptoms. The mass is barely palpable and non-tender.

Case No. 2: The patient was a 60 year old woman, who had dyspnea of increasing severity for six months. She had been told six years previously that she had a "hernia of bowel in the chest." In addition to dyspnea, she had noted ankle edema and severe alternating constipation and diarrhea for one year. Her admission was precipitated by severe paroxysmal nocturnal dyspnea.

Despite these symptoms, the patient appeared healthy. She was obese. The blood pressure was 150/90. The dyspnea was confirmed by physical examination and the entire left chest was dull, and breath sounds were absent. Occasional peristaltic rushes could be heard in the chest. There was minimal ankle edema.

The preoperative evaluation failed to disclose any evidence of primary cardiac disease. Gastrointestinal series confirmed the presence of a massive hiatus hernia.

The hemoglobin on admission was normal. In view of the cardiovascular symptoms and the surgery contemplated, a blood volume study was ordered. This study showed an unexpected excess of blood volume which was equal in all compartments. Because of this finding, blood was withheld until the hernia was reduced and replacement was limited to less than was originally anticipated.

The surgical procedure consisted of reduction of the herniated stomach, spleen, omentum, and colon into the abdominal cavity and repair of the defect. The lower lobe and the lingular segment of the upper lobe of the left lung were pink and free of anthracosis indicating that the hernia had been present many years and these segments of lung had had minimal respiratory function.

The postoperative course was uneventful. The dyspnea and gastrointestinal symptoms were corrected by the procedure.

Case No. 13: This patient had a carcinoma of the esophagus, which was resected. Continuity was restored by anastomosis of the distal third of stomach to the esophagus just below the aortic arch.

The preoperative blood volume study showed an increase in blood volume of 40 per cent, which had been interpreted on the basis of the patient's preoperative weight of 125 pounds. In view of the rapid starvation of this patient from a normal weight of 170 pounds, this patient *did not* have a blood volume excess, and was treated accordingly during the operative procedure. The postoperative course was complicated on the sixth postoperative day by an acute myocardial infarction, which the patient survived. He was discharged on the thirty-fifth postoperative day.

## Discussion

Blood volume measurement is a standardized laboratory technique that can be performed in the clinical laboratories of small general hospitals.[3] The method utilizing red blood cells tagged with $Cr^{51}$ is slightly more accurate than methods measuring plasma volume.[4] Knowledge of the blood volume is essential in the management of surgical problems in the aged, chronically ill patient, and cannot be supplanted by clinical estimates, guesswork, or hemoglobin determina-

TABLE 1. *Consecutive Cases Studied*

| Pt. | Age | Wt. | Adm. Hgb. | Diagnosis | Operation(s) | Result |
|---|---|---|---|---|---|---|
| 1 | 83 | 125 | 13.3 | Carcinoma sigmoid colon Thromb. L. sup. fem. artery | (1) Trans. colostomy, (2) Sig. resection (3) L. fem. arteriotomy, (4) Closure of colostomy, (5) L. low thigh amputation | Alive & Well |
| 2 | 60 | 150 | 13.9 | Hiatus hernia | (1) Left transthoracic hiatus herniorrhaphy | Alive & Well |
| 3 | 73 | 200 | 12.9 | Cholecystitis, Choledocholithiasis | (1) Cholecystectomy, Choledochotomy | Alive & Well |
| 4 | 72 | 125 | 12.0 | Carcinoma of stomach | (1) Exp. thoracotomy, gastrotomy | Alive w/disease |
| 5 | 78 | 140 | 13.3 | Carcinoma of sigmoid | (1) Trans. colostomy, (2) Sig. resection, (3) Closure of colostomy, (4) TUR | Alive & Well |
| 6 | 33 | 95 | 13.0 | Multiple sclerosis, fecal impaction, pelvic abscess with peritonitis, partial small bowel obstruction | (1) Sigmoid colostomy, lysis of small bowel adhesions | Alive & Well |
| 7 | 59 | 115 | 14.1 | Radiation stricture of sigmoid colon, multiple adhesions with small bowel obstruction | (1) Sigmoid colostomy, lysis of small bowel adhesions | Alive & Well |
| 8 | 64 | 170 | 12.3 | Carcinoma of stomach | (1) Gastroenterostomy, enteroenterostomy | Died 6 Mo. post-op. |
| 9 | 57 | 184 | 12.2 | Empyema of gallbladder | (1) Cholecystectomy | Alive & Well |
| 10 | 75 | 215 | 12.2 | Carcinoma of sigmoid | (1) Sig. resection, (2) Suture of dehiscence | Alive & Well |
| 11 | 48 | 145 | 9.0 | Hepatic cyst with obstruction of choledochus, cholangitis | (1) Choledochotomy, cyst-jejunostomy, sphincterotomy | Alive & Well |
| 12 | 42 | 175 | 5.6 | Duodenal ulcer | (1) 50% gastrectomy, vagotomy | Alive & Well |
| 13 | 60 | 124 | 11.9 | Carcinoma of esophagus | (1) Thoraco-abdominal resection distal esophagus and proximal stomach | Alive & Well |

tions. On the other hand, as illustrated in the last case presented, the blood volume value cannot replace common sense. Just as in many other laboratory determinations, it is necessary to have a working knowledge of the factors which influence the result both in health and disease.

**Regulation of blood volume.** The homeostatic mechanisms in the body tend to maintain the volume of blood remarkably constant. The sensing devices are volume ("stretch") receptors in the atria of the heart and baroreceptors in the carotid sinus that are primarily concerned with regulation of the extracellular fluid volume in the intravascular compartment.[5] The intermediary for the former is the pituitary-water secretion mechanism and for the latter the aldosterone-salt excretion system. The organ effecting the final result is the kidney. A midbrain receptor and intrinsic renal mechanism are also postulated but are not completely understood at present.

Therefore, as the red cell mass decreases there is a tendency for normal blood volume to be maintained by a concomitant expansion of the plasma compartment. The findings in the cases presented are in agreement with other reports in the literature, including a group of elderly cachectic patients,[2] starved prisoners of war,[6] and normal volunteers who were starved and developed famine edema.[7] The expansion of the plasma space is *not* related to plasma protein deficiency but will occur even if plasma proteins are further diluted by the process.[8]

**Evaluation of blood volume in relation to hematocrit and body weight.** After the blood volume is measured, the result is given in relation to the hematocrit and the body weight. Both are therefore potential sources of error. In humans, the body hematocrit/venous hematocrit ratio is constant and the corrective factor introduces no important error. In splenomegaly and in prolonged prednisone therapy with extravascular fluid retention this ratio may be altered and thereby introduce error.[9]

There is no change in blood volume with relatively slight loss of weight. When more severe degrees of weight loss are being evaluated it becomes important to decide whether it was fat that was lost or lean body tissue. The lean body mass, as measured by the antipyrine space has a blood content of 54 ml kg, whereas fat tissue has a blood content of 11 ml kg.[10] The blood volume on a given patient must be compared with a *lean normal* value. In other words, an obese patient will have a smaller blood volume than a lean patient of the same weight. In a patient who has lost mostly fat, the weight used for "normal" comparison should be the *present weight* or close to it. A patient who has wasted muscle tissue by starvation, particularly if the process has been rapid, should be compared by his *former weight* in assessing what his normal blood volume should be. It follows that the largest errors are introduced where large weight changes are a part of the clinical picture. The physician must be cautious in interpretation when this condition exists.

**The use of packed cells.** In replacement of blood preoperatively, except for fresh hemorrhage, first consideration should be given to the use of packed red blood cells. The reason is the common finding of an increased plasma space in conditions where blood volume deficits are present. Even in hemorrhage there may be a pre-existing plasma excess of dangerous dimensions as the first case presentation illustrates. The use of packed cells allows full replacement of oxygen carrying capacity in a 40 per cent smaller volume.

There are other important advantages to the use of packed cells.[11] Stored whole blood usually has a

TABLE 2. *Blood Volume Data*

| Pt. | Age | Wt. | Adm. Hgb. | Measured Value | | | | Theoretical Value | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Hct. % | Bl. Vol. cc | Pl. Vol. cc | RBC Mass cc | Blood Volume Range | Blood Volume Mean | Plasma Volume Range | Plasma Volume Mean | RBC Mass Range | RBC Mass Mean |
| 1 | 83 | 125 | 13.3 | 37 | 3530 | 2340 | 1190 | 3350-4150 | 3750 | 1940-2365 | 2152 | 1410-1785 | 1597 |
| 2 | 60 | 150 | 13.9 | 46.5 | 5440 | 3140 | 2300 | 4020-4980 | 4500 | 2340-2890 | 2615 | 1680-2090 | 1885 |
| 3 | 73 | 200 | 12.9 | 37 | 6880 | 4560 | 2320 | 5360-6640 | 6000 | 3110-3850 | 3480 | 2250-2790 | 2520 |
| 4 | 72 | 125 | 12.0 | 39 | 4200 | 2700 | 1500 | 3970-4830 | 4400 | 2184-2857 | 2520 | 1786-1973 | 1879 |
| 5 | 78 | 140 | 13.3 | 48 | 4090 | 2310 | 1780 | 4450-5420 | 4935 | 2448-3001 | 2724 | 2002-2419 | 2211 |
| 6 | 33 | 95 | 13.0 | 41.5 | 2930 | 1812 | 1118 | 2550-3160 | 2855 | 1480-1810 | 1645 | 1070-1350 | 1210 |
| 7 | 59 | 115 | 14.1 | 43 | 3930 | 2390 | 1540 | 3080-3820 | 3450 | 1789-2210 | 1999 | 1291-1610 | 1451 |
| 8 | 64 | 170 | 12.3 | 41 | 5450 | 3420 | 2030 | 4560-5640 | 5100 | 2630-3270 | 2950 | 1930-2370 | 2150 |
| 9 | 57 | 184 | 12.2 | 38 | 6250 | 3980 | 2270 | 5880-7150 | 6515 | 3234-3933 | 3583 | 2646-3217 | 2931 |
| 10 | 75 | 215 | 12.2 | 38 | 7825 | 4910 | 2915 | 5850-8275 | 7052 | 3220-4510 | 3865 | 2630-3765 | 3197 |
| 11 | 48 | 145 | 9.0 | 31 | 4650 | 3340 | 1310 | 3890-4820 | 4355 | 2255-2760 | 2507 | 1635-2060 | 1848 |
| 12 | 42 | 175 | 5.6 | 23 | 3900 | 3150 | 750 | 5570-6790 | 6170 | 3064-3724 | 3394 | 2506-3046 | 2776 |
| | | | 10.7 | 34 | 5620 | 3880 | 1740 | | | | | | |
| 13 | 60 | 124 | 11.9 | 35.5 | 6130 | 4150 | 1980 | 3970-4830 | 4400 | 2184-2857 | 2520 | 1786-1973 | 1879 |

TABLE 3. *Percentage Variation of Measured Value from Theoretical Mean Value*

| Pt. | Age | Wt. | Adm. Hgb. | Diagnosis | Blood Volume % | Plasma Volume % | RBC Mass % |
|---|---|---|---|---|---|---|---|
| 1 | 83 | 125 | 13.3 | Ca. sigmoid colon | − 6 | + 9 | −26 |
| 2 | 60 | 150 | 13.9 | Hiatus hernia | +21 | +20 | +22 |
| 3 | 73 | 200 | 12.9 | Cholecystitis | +15 | +31 | − 8 |
| 4 | 72 | 125 | 12.0 | Ca. stomach | − 5 | + 7 | −21 |
| 5 | 78 | 140 | 13.3 | Ca. sigmoid | −17 | −15 | −20 |
| 6 | 33 | 95 | 13.0 | Peritonitis | + 3 | +10 | − 8 |
| 7 | 59 | 115 | 14.1 | Sm. b. obstruction | +14 | +20 | + 6 |
| 8 | 64 | 170 | 12.3 | Ca. stomach | + 7 | +16 | − 6 |
| 9 | 57 | 184 | 12.2 | Empyema of g. b. | − 4 | +11 | −23 |
| 10 | 75 | 215 | 12.2 | Ca. sigmoid | +11 | +27 | − 9 |
| 11 | 48 | 145 | 9.0 | Obst. jaundice | + 7 | +30 | −29 |
| 12 | 42 | 175 | 5.6 | Duodenal ulcer | −37 | − 7 | −73 |
| | | | 10.7 | | − 9 | +15 | −37 |
| 13 | 60 | 124 | 11.9 | Ca. esophagus | +39 | +65 | + 5 |

large amount of extracellular potassium, sodium, and citrate ions, all undesirable in certain clinical situations, and the amount of these ions is quantitatively reduced by removal of the plasma prior to infusion.

The removal of plasma from group O blood will permit the safe infusion of the cells into compatible recipients that are not group O. Group AB recipients, hard to supply with blood, can receive compatible packed cells from available groups other than AB.

Packed cells should also be used postoperatively if a significant anemia exists since plasma space expansion is a recognized postsurgical response.[12,13]

## Summary and Conclusions

Blood volume determinations are indicated in all cachectic patients, in patients with a history of recent bleeding, and in preoperative patients with a history of coronary insufficiency or congestive heart failure. Proper evaluation of the result will permit surgical procedures of a greater magnitude to be performed more safely on these patients.

The result returned from the laboratory must be interpreted in relation to known factors that affect blood volume in health and disease. These factors are discussed.

The most frequent abnormality found is an expansion of the plasma space.

If a deficit exists, first consideration should be given to the use of packed red blood cells for replacement therapy, and adequate time allowed for renal mechanisms to correct the extracellular intravascular space expansion.

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A MARSHMALLOW BOLUS is a valuable aid to radiologic examination of the esophagus. If a whole marshmallow can be swallowed without clinical or radiologic evidence of an esophageal abnormality the presence of esophageal disease is unlikely.—J. Edward Kelly, Jr., M. D., Boston: *The New England Journal of Medicine,* 265:1306-1307, December 28, 1961.

# Intrathoracic Lipoma

## Report of Successful Removal of a Large Tumor

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A LARGE intrathoracic opacity is a difficult lesion to diagnose when visualized by radiologic methods. Recently, such a case was seen in which the diagnosis was made only by exploratory thoracotomy. This tumor weighed 9 pounds and is the largest intrathoracic lipoma reported with successful resection.

Lipomas occur infrequently within the thorax. Williams[9] and Parsons, in their excellent review of the subject in 1957, reported 68 cases in the world literature. The largest tumor, described by Leopold in 1920,[6] weighed 17 pounds, 6 ounces. The diagnosis of this tumor was made at autopsy. In 1954, Crutcher and Plott[1] reported primary resection of an 8 pound, 1 ounce intrathoracic lipoma. In 1957, Ansaldo, et al., resected a 4050 gram lipoma in two stages, four months apart. Four additional cases appearing in the world literature have not been added to the previous total.[7] The case presented here is the seventy-third intrathoracic lipoma reported in the world literature.

### Case Report

In January 1960, a 35 year old white male laborer had a routine chest x-ray, which disclosed a left thoracic density. This was investigated further by another x-ray one month later. He was admitted to a sanatorium for evaluation of the findings. Sputum specimens were negative for acid-fast bacilli. He was transferred to the Ohio Tuberculosis Hospital on May 10, 1960.

The patient was completely asymptomatic except for a 14 pound weight gain during the previous six months. Past history indicated that he had been rejected by the U. S. Army in 1943 because of "an enlarged heart." A chest x-ray in 1945 was reported to the patient as being normal.

On examination, he was a well developed and well nourished man exhibiting no respiratory distress. Blood pressure was 130/90, pulse rate 96 per minute, respiratory rate 20 per minute, weight 162 lbs., and height 5'11¾". There were decreased excursion, decreased fremitus, and dullness over the left lung. The cardiac impulse was felt at the right sternal border in the fourth intercostal space. The remainder of examination was entirely normal.

Chest x-ray examination showed a dense opacification of the lower two thirds of the left hemithorax with mediastinal and cardiac displacement to the right (Fig. 1). The esophagus was displaced to the right, when visualized by barium swallow. Bronchograms disclosed extrinsic compression of the left lower main stem bronchus. Bronchoscopy confirmed this. On May 17, a thoracentesis was attempted but yielded no fluid.

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Skin test with intermediate strength PPD was 1 plus, and with histoplasmin 1 plus. Three gastric aspirations and one sputum specimen were negative for acid-fast bacillus. Hemoglobin was 17 Gm. per 100 ml., hematocrit 48 per cent, white blood cell count 6,300 with a normal differential, prothrombin time 75 per cent, and urinalysis normal. The preoperative diagnosis was a benign tumor of the left chest. Also considered were teratoma and mesothelioma.

On June 1, 1960, exploratory thoracotomy was performed through the left fifth intercostal space. On entering the pleural space, a well encapsulated, soft, pale yellow mass extended from the diaphragm to the region of the fourth rib superiorly. The left lower lobe was markedly collapsed and the upper lobe was moderately collapsed. The pleural space was free of adhesions, and the tumor was delivered without difficulty. The vascular pedicle of the mass, which was attached to the antero-superior mediastinum, contained a pair of medium sized vessels. These were clamped, divided, and doubly ligated, and the tumor was removed through the wound. The left lung expanded well, but it did not entirely fill the left hemithorax. Two drains were inserted into the pleural space and the chest wall was closed in a routine manner with interrupted silk. The patient had no anesthetic complications.

The tumor mass measured 32 by 25 by 20 cm. and weighed 9 pounds (4100 grams) (Fig. 2). Microscopic sections showed normal adult adipose tissue.

Postoperatively, he did very well except for a temperature elevation to 38.8°C. on the second day. Thereafter the course was complicated by hydrothorax which required five thoracenteses and removal of 3255 cc. of serosanguineous fluid (specific gravity 1.016). A chest x-ray on the fortieth postoperative day showed a small pneumothorax at the left apex with good expansion of the left lung. The mediastinum was in the mid-line. He was discharged three

days later, on July 13, 1960. A follow-up x-ray ten weeks after surgery showed a slight elevation of the left hemidiaphragm (Fig. 3).

## Discussion

In 1783, Fothergil described the first intrathoracic lipoma. These tumors were anatomically classified by Heuer in 1933.[4] Williams and Parsons, in 1957,[9] divided them into three groups: (1) Intrathoracic group, in which the tumor lies entirely within the thoracic cage; (2) the "hour-glass" group with intrathoracic and extrathoracic portions and subdivided into: *a.* cervico-mediastinal, and *b.* transmural with extension through the sternum or an intercostal space;




FIG. 1. *Chest x-ray demonstrating a 4100 gram intrathoracic lipoma.*

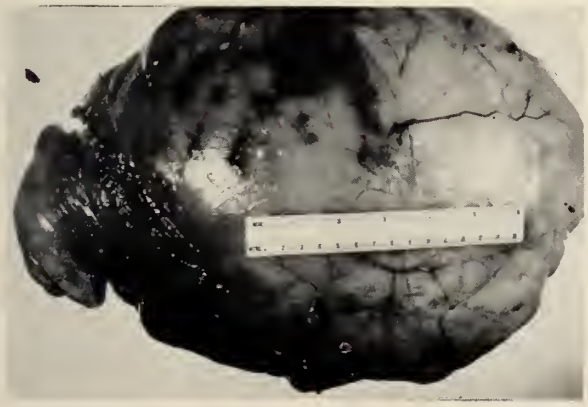


FIG. 2. *Gross appearance of the 9 pound intrathoracic lipoma.*




FIG. 3. *Postoperative chest x-ray — 10 weeks.*

and (3) "miscellaneous," including intrabronchial lipomas and those arising from the external surface of the heart. Microscopically, intrathoracic lipomas are usually composed entirely of adult adipose tissue. Hibernomas (a misnomer) are a rare variant composed of fetal adipose cells. They receive their name from the brown color of the fat tissue, which is similar to the fat of hibernating animals. Lipothymomas and fibrolipomas are mixed-cell tumors and should not be included in the category of lipomas.

A correct preoperative diagnosis of intrathoracic lipoma is not common. Needle aspiration of fatty material and pleuroscopy have been of diagnostic value in isolated cases.[8] The radiographic demonstration of a clear peripheral zone around the tumor (Heuer's sign) is of value if present.[4] However, thoracotomy is the only method of accurately diagnosing these tumors.

Unless there is tracheal or marked bronchial compression, these tumors are generally asymptomatic, but some authors have reported cough, dyspnea, and shortness of breath.[5]

The postoperative course of patients from whom a large lipoma has been removed is similar to that of patients undergoing other thoracotomy procedures except for the development of serous or serosanguineous pleural fluid. In this case there were no pleural adhesions, raw tumor bed, or other obvious source for a transudate. It is therefore postulated that, after

a lung has been markedly compressed for a long period of time and then is suddenly allowed to re-expand, a transudate will exude from the lung surface.

### Conclusions

1. There are 73 cases of intrathoracic lipoma reported in the world literature.

2. This case, in which the tumor weighed 9 pounds (4100 grams), is believed to be the largest with successful resection.

3. A correct preoperative diagnosis of intrathoracic lipoma is infrequent, although a positive Heuer's sign on chest x-ray, fatty aspirate on thoracentesis, or pleuroscopy have been diagnostic in other cases.

4. It is postulated that the postoperative accumulation of a transudate in the pleural space is due to the sudden reexpansion of a chronically compressed lung.

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## Results of Hypotensive Therapy In Arterial Hypertension

The results of hypotensive treatment over a period of eight years are reviewed. There were 497 patients on hypotensive therapy and 156 controls. The improvement with treatment in the mortality of retinal grade 4 and grade 3 patients is confirmed. There has been a highly significant improvement in the mortality of retinal grade 2 patients, 61 deaths occurring among 242 treated grade 2 patients (all ages) as contrasted with 43 among 88 controls.

The relative loss of life-years during the eight-year period of study was nearly three times as great in grade 2 controls as in grade 2 treated patients. . . .

Taking all grades together, despite the predominance of severe retinal grades in the treated patients there was a reduction in the death rate (as a percentage of patients at risk) from heart failure and from cerebral vascular accidents in the patients on hypotensive therapy.

The decreased mortality does not appear to depend upon which particular measures are used to reduce the blood-pressure. The consistent aim of our hypotensive therapy has been to reduce the blood-pressure level of hypertensive patients to as near normal as practicable. No claim is made for the efficacy of less substantial reductions of the blood-pressure.—J. V. Hodge, M. D., et al., Dunedin, New Zealand: *British Medical Journal,* 5218:1-7, January 7, 1961.

## Franklin County Pelvic Cancer Delay Committee Report

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee at its September 19 meeting.

Case No. 105: The patient is a 51 year old white woman, gravida V, Para V, who underwent spontaneous menopause in 1959. Approximately three months ago, she experienced several episodes of vaginal bleeding which prompted her to see her family physician. At this time a pelvic examination was performed and she was treated with hormone medication and vinegar douches. She was seen on two subsequent occasions by the same physician who continued medical therapy along similar lines. Since vaginal bleeding persisted, the patient presented herself to the Emergency Room of University Hospital complaining of weakness and vaginal bleeding. Pelvic examination revealed the entire cervix to be replaced by an exophytic, friable lesion which nearly filled the upper vagina. Induration and thickness were palpable along the sacral uterine ligament. Uterus and adnexa were essentially of normal size and consistency. The clinical impression was squamous cell carcinoma of the cervix. She was admitted to the hospital and a dilatation, curettage and cold knife conization confirmed the clinical impression of cervical carcinoma. She was treated with central cobalt therapy, 3000 roentgens to point A. Upon discharge from the hospital arrangements were made for this patient to receive 5,000 roentgens to the midpelvic plane by cobalt teletherapy.

### Comments

This case illustrates a physician delay factor of three months during which time medical therapy was administered to a patient with vaginal bleeding without benefit of a definite diagnosis. Approximately 30 to 50 per cent of all postmenopausal bleeders have cervical or endometrial carcinoma. If a patient presents herself at a physician's office for a routine annual examination, a Papanicolaou smear from the posterior fornix and cervical scraping should be included in the routine examination particularly in the pre- and postmenopausal age group.

If a patient presents herself to the physician's office complaining of dysfunctional uterine bleeding around the age mentioned, then dilatation and curettage and cold knife conization of the cervix should be performed not only to rule out uterine carcinoma but also other neoplasms, which may be the cause of this bleeding. In postmenopausal bleeding, such a diagnostic procedure will often be rewarded with a diagnosis of uterine carcinoma even though the lesion is not visible or palpable.

If a patient should present herself in the physician's office with uterine bleeding at any age and a cervical lesion is visualized, an office biopsy is justifiable for the purpose of making a definite diagnosis. Otherwise, the patient should be admitted to the hospital and a diagnostic dilatation, curettage and, adequate biopsy of the cervical lesion done. In view of the high incidence of concealed malignant tumor of the uterus in women with postmenopausal bleeding, there is no place for conservative medical therapy such as that given in this case.

*Physician Delay*—Three Months.

*Patient Delay*—None.

# The Clinical Evaluation of the Heart

## III. Abnormalities of the Second Heart Sound

DANIEL K. BLOOMFIELD, M.D.*

THE heart page of last month described the normal second heart sounds. When the normal is well appreciated, abnormalities stand out clearly as landmarks to diagnosis and therapy. Suppose, for example, a young patient exhibits a somewhat rough pulmonary ejection murmur, and shows dilatation of the pulmonary artery by x-ray. A tentative diagnosis of pulmonary stenosis would be in order, and, in many institutions, cardiac catheterization would be done to measure any gradient across the pulmonary valve. If such a patient had normal splitting of the second heart sound, hemodynamically significant pulmonic stenosis could be categorically denied without the need of so much as an x-ray or electrocardiogram, not to mention the more elaborate procedure of catheterization. A normal split in this case, as I have explained previously, means normal closure of a clearly heard inspiratory split to a single sound at the end of expiration. Significant stenosis of the pulmonary valve invariably delays closure of the pulmonic semilunar valve and leads to an open split audible in both phases of respiration. Since pulmonary ejection murmurs are frequently heard in childhood, it would not be an exaggeration to estimate that hundreds of unnecessary cardiac catheterizations are done each year throughout the world for lack of appreciation of this simple fact. This type of case is described to emphasize that the abnormal second sound can only be identified and used when the normal sound movements are well understood.

The most common abnormality of the second heart sound is its failure to close at the end of expiration. This may be observed for two main reasons, $P^2$ (closure of the pulmonic semilunar valve) is delayed, or $A^2$ (closure of the aortic semilunar valves) is early. By itself an open split on expiration is a normal variant. Sometimes the second sound becomes single only once every four or five respiratory cycles. But in those few instances of normal hearts where the split remains open throughout expiration, the split is easily observed to be moving, that is, opening to perhaps 0.05 seconds on inspiration and closing to 0.02 seconds on expiration. While no one expects a physician to casually time these events to hundredths of a second, anyone can discern the differences in timing of two splits when one is more than twice as wide as the other.

An abnormally wide split due to a delay in $P^2$ is chiefly associated with four conditions: atrial septal defect (ASD), pulmonic stenosis (PS) with normal aortic root, right bundle branch block, and acute right heart overload. The wide split in ASD has proved useful and reliable. Delayed pulmonic closure is thought to be due to prolonged right ventricular ejection from the persistent volume overload caused by the left to right shunt. Simultaneously, aortic closure may be early because left ventricular ejection is shortened due to a relatively smaller stroke output. This logical explanation fails to explain why the normal split may persist for years after surgical closure of the defect, but such considerations do not lessen the practical utility of the phenomenon. The split in ASD is best described as persistent rather than fixed. In cases of large left to right shunts the split is wide (about 0.06 seconds) and fixed at this width in both phases of respiration. When the ASD is smaller, the second sound may move but remains persistently open on expiration. These relationships may change when pulmonary hypertension complicates ASD (less than 20 per cent of cases), but in the absence of elevated pulmonary artery pressure the split is abnormal in 100 per cent of cases and the diagnosis of ASD is untenable without it.

Pulmonary valve stenosis, as mentioned above, is also associated with wide splitting of the second sound. The delay in $P^2$ is due to prolonged right ventricular ejection through a stenotic orifice. The delay of $P^2$ is roughly proportional to the degree of stenosis. In severe cases the wide split may not be heard because $P^2$ is diminished and $A^2$ obscured by the loud, long pulmonary ejection murmur.

Aside from congenital heart disease, the broadened split of the second heart sound can be crucial in the difficult diagnosis of acute right heart overload (e.g. acute pulmonary embolus). This deserves more than casual notice and will be treated separately in another heart page.

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The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

*Dr. Bloomfield, Cleveland, Senior Instructor in Medicine, Western Reserve University School of Medicine, is an Established Investigator of the American Heart Association.

# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT P. CARSON, M.D., *President*

PRESENTATION OF CASE

THIS 32 year old white female medical technician began noting generalized weakness, easy fatigability and shortness of breath on exertion about a year prior to admission. She was also aware of a fast pulse, palpitation, and increased tolerance to cold. One month prior to hospitalization her shortness of breath became more severe; she noted dyspnea on one flight of stairs, and had the first of several episodes of severe nocturnal dyspnea. She was admitted to a local hospital and was felt to have thyrotoxicosis and rheumatic heart disease with mitral stenosis and insufficiency and congestive heart failure. She had a palpably enlarged thyroid, left atrial enlargement by x-ray and pulmonary congestion. She was treated with digitalis, diuretics and Tapazole.® She did not significantly improve and after 42 days was transferred to University Hospital. She had had a weight loss of 15 to 20 lbs. in spite of a good appetite. There had been no nausea or vomiting, and bowel habits were regular. She had no excessive perspiration; there had been no fever.

### Physical Examination

The blood pressure was 110/80, pulse rate 120 per minute, respiratory rate 24 per minute. She appeared thin, chronically ill, and obviously short of breath. The skin was smooth, warm and moist. Stare and lid lag were noted. The thyroid was diffusely moderately enlarged. The lungs were clear to auscultation. On examination of the heart the point of maximum impulse was forceful; the pulmonic second sound was increased and the apical first sound was accentuated. The rhythm was regular; a diastolic gallop could be heard and felt. A grade 2 soft blowing systolic murmur was heard at the apex and a grade 2 diastolic murmur along the left sternal border and at the apex. The abdomen was normal. There was no peripheral edema or cyanosis. Fine tremor in the hands and generalized muscle weakness were present. Neurological examination was normal.

### Laboratory Data

The hemoglobin was 11.9 Gm., hematocrit 38 per cent; the white blood cell count was 6800 with a normal differential count; platelets were 98,000. Negative laboratory studies included urinalysis, blood urea nitrogen and creatinine, blood sugar, uric acid, serum calcium, total protein and A/G ratio, thymol turbidity, cholesterol, febrile agglutinins, blood culture, LE preparations, Watson-Schwartz and catechol amine excretions. Latex fixation was positive 1:640. Radioactive iodine uptake was 29 per cent and on repeat was 16 per cent. Protein-bound iodine was 5.8 and 7.7 mcg. per 100 ml. The basal metabolic rates were +16, 12 and 18.

Submitted August 9, 1962.

*Presented by*

- James J. Leonard, M.D., Columbus, and
- Dante G. Scarpelli, M.D., Columbus.

Edited by Dr. Scarpelli.

### Hospital Course

On admission the patient was thought to have thyrotoxicosis and rheumatic heart disease with mitral valve involvement. Propylthiouracil was started and digitalis continued. The pulse rate remained elevated above 100/min. Cardiac fluoroscopy on the second day showed an enlarged left atrium, generalized cardiac enlargement, prominent pulmonary vascular markings, bilateral pleural effusion, a pneumonic infiltration in the left upper lobe and a diffuse nodularity in both lungs. Electrocardiogram showed prominent P waves, right axis deviation, right ventricular enlargement, and sinus tachycardia. Symptomatic shortness of breath increased, and the pulse rate remained elevated in spite of increasing doses of digitalis.

On the sixth day she developed a temperature elevation to 101°; this persisted. Chest x-ray showed persistent pneumonitis in the left lung. Rales in both lungs continued, as did the gallop rhythm, and the patient became orthopneic. Biopsies of a left axillary node and left deltoid muscle were not diagnostic. The patient was obviously deteriorating despite therapy. Arterial studies on the nineteenth day showed oxygen saturation of 84.8 per cent at rest with a carbon dioxide pressure of 33.6 mm. Hg and pH of

7.51. With effort the $O_2$ saturation rose to 86.2 per cent and with administration of 100 per cent oxygen it rose to 99.4 per cent. Because of increasing dyspnea and the possibility that this represented primary pulmonary hypertension, Decadron®, 2.0 mg. four times daily, was started on the nineteenth day. A left thoracentesis on the twenty-second day yielded 60 cc. of clear fluid with a specific gravity of 1.010, containing 37,000 red blood cells and 40 white blood cells/cu. mm., protein of 2400 mg./100 ml., no organisms on smear or culture. She never improved, suffered vascular collapse and died on the twenty-fourth hospital day.

## CLINICAL DISCUSSION

DR. LEONARD: This patient was a 32 year old woman who had noted generalized weakness, fatigability and shortness of breath for about a year prior to admission. She also had a fast pulse, palpitations, and had noted increased tolerance to cold. Everything thus far suggests that she possibly had hyperthyroidism and certainly the palpitation would go along with this. These people do have a fast heart rate and because they have a wide pulse pressure they are frequently very conscious of their hearts in much the same manner as is a patient with aortic insufficiency. If they also develop a few extrasystoles they become extremely conscious of their palpitation.

### More Than Thyrotoxicosis

One month prior to hospitalization her shortness of breath became more severe and she noted dyspnea on one flight of stairs. Although we can't explain it, nevertheless most patients with hyperthyroidism will tell you that they are short-winded and frequently complain of some precordial aching pain. Studies on the mechanics of respiration tell us that for the most part people with hyperthyroidism are normal and yet they do have these complaints. Up to this point her dyspnea could be explained by hyperthyroidism alone. But then she developed several episodes of severe nocturnal dyspnea, which suggests that something else is going on, because patients with hyperthyroidism uncomplicated by heart failure don't have this type of dyspnea. As I read this protocol I felt sure that she probably did not die of hyperthyroidism and that a second disease was present which accounted for her death.

The enlarged thyroid was not the type that would make one think of cancer of the thyroid with metastasis to the lungs or heart that might give cardiovascular-respiratory difficulties. The fact that left atrial enlargement is mentioned again and again means to me that this must have been out of proportion to the rest of the heart. Occasionally a patient with hypertension goes in and out of failure and develops a left atrium that is larger than one would expect in congestive heart failure. In general, when anybody with a normal-sized or slightly enlarged heart has a prominent left atrium, and it has to be pretty prominent before it is picked up by the usual x-ray technic, it suggests to me that we should look for something specific that leads to greater enlargement of the left atrium than of the other chambers—mitral stenosis, for example.

We do not know how long the digitalis, diuretics and Tapazole were continued, but if she had hyperthyroidism she should have responded to Tapazole in 42 days. She may not have been cured of her hyperthyroidism but she should have improved if this was a major part of her disease. The 15 to 20 lb. weight loss in spite of a good appetite is an excellent historical observation consistent with hyperthyroidism. She did not have perspiration, and she had no fever until just prior to death. If she had rheumatic heart disease, she might have a superimposed bacterial endocarditis which would explain why she did poorly, but in this case we would like to have her have more fever sometime during her hospital course.

On physical examination she had a very unusual blood pressure for hyperthyroidism. Most patients with hyperthyroidism and the circulatory changes accompanying it will have a blood pressure averaging 170-160/75 with a narrow pulse pressure in spite of the rapid rate. Her blood pressure was 110/80. The pulse rate of 120 is compatible with hyperthyroidism. On the other hand, patients, let us say with hypertensive or arteriosclerotic heart disease that slip into heart failure, will have much lower rates than this with a normal sinus rhythm. She was also obviously short of breath and from the description had the classic skin of hyperthyroidism. I emphasize this, here, because her laboratory data do not seem to indicate that she was hypermetabolic at the time we saw her.

### Significance of Gallop

All of her precordial and auscultatory findings could be explained on the basis of hyperthyroidism alone. She had a diastolic gallop which could be heard and felt. I think it is important. It is a rapid filling sound and may come from either the left or the right side of the heart. If it came from the left side, and she should have rapid filling of this side of her heart, then she does not have significant mitral stenosis. On the other hand, she could have significant mitral stenosis and a right heart gallop. But she did not show any signs of right heart failure at that time. I believe that finding would lead us away from the opinion that she had tight mitral stenosis, although you can have tight mitral stenosis and a gallop rhythm from rapid right heart filling.

The murmurs are difficult to put together. There was a grade 2 soft blowing systolic murmur at the apex. On the other hand, a diastolic murmur was heard along the left sternal border and at the apex, and I gather that they are describing a blowing murmur of a semilunar valve insufficiency. That is

to say, this indicates that she had either pulmonic or aortic insufficiency. It is not too significant hemodynamically if it is aortic insufficiency, but it would tell you that she had an abnormal valve and could be a candidate for acute or subacute bacterial endocarditis.

On the other hand, if it is pulmonic valve insufficiency, this means severe pulmonary hypertension and may point towards the fact that this woman had primary pulmonary hypertension or was having multiple pulmonary emboli with pulmonary hypertension. This is like the Graham Steell murmur and could be secondary to mitral stenosis. Although they are unusual, there are cases of tight mitral stenosis with no rumbling, no opening snap, and multiple pulmonary emboli. In such a case the tip-off may be ancillary findings such as calcification of the mitral valve or calcification of the left atrium, but here we have to rely on roentgenography for some help. In spite of all this difficulty she had no peripheral edema.

Most of her laboratory findings are helpful in being negative. Her radioactive iodine and protein-bound iodine determinations were within normal range. I do not know exactly how to explain this, but I know there are many things that can interfere with both of them, and I gather that she probably was on Tapazole up until the day she came into our hospital and this might explain the results. Her basal metabolic rate is not very high either, especially for a patient in heart failure. It is unusual to get a basal metabolic rate this low on a patient in heart failure because they are dyspneic and are usually not really "basal" when the test is run. In spite of the laboratory tests I would say she probably had mild to moderate hyperthyroidism, but again I don't know how it fits into the overall picture.

They started treatment of the patient with propylthiouracil. As sick as she turned out to be, you would think they would have treated her with Tapazole or some faster acting preparation if they thought her hyperthyroidism was adding to her heart failure. Her pulse rate remained high, and her x-ray films showed a number of findings that perhaps Dr. Freimanis can explain to us now.

### Discussion of X-Rays

Dr. A. K. Freimanis: In this first film the heart is enlarged, and there is a pleural effusion on the right side. The lungs show a peculiar but fairly diffuse increase in the vascular pattern most likely on a congestive basis. Enlargement of the left atrium is suggested by upward displacement of the left mainstem bronchus and some straightening of the left heart border.

Dr. Leonard: Do you think the appendage is enlarged as well as the atrium?

Dr. Freimanis: There is evidence that the appendage was also enlarged. The vascular pattern in the lung fields is sometimes said to be characteristic of people with mitral valve lesions but I really don't think this is a classic case of that. I think the increase in the vascularity is due to congestion and may be evidence of pulmonary hypertension. As her disease progressed, the fluid on the left increased and the congestion gradually increased. The last film shows a marked increase in the amount of fluid, probable areas of pulmonary edema, increase of fluid on the right side, and enlargement of the heart as compared to the previous film. You mentioned bacterial endocarditis. We don't see any change in the pattern of cardiac enlargement as she became worse. One chamber did not change more than any other chamber. Could there be multiple pulmonary emboli and nothing else? Again I believe one would find more right-sided enlargement and would not find evidence of left atrial enlargement.

Dr. Leonard: I was interested in the straightening of the right border of the heart, if it really is the atrial appendage. Of course this really is more or less characteristic of mitral valve disease of some type. There are some congenital diseases in which you see left atrial enlargement, but usually the whole atrium is enlarged, whereas in mitral valve disease, for some reason that nobody has yet explained, the appendage participates in this enlargement. I think there is good evidence here that there is truly some kind of disease involving the mitral valve that is causing this type of enlargement. The disseminated lesion in the lung now turns out to be congestive changes, not quite like one finds in long-standing mitral stenosis but of congestion over a period of time.

### Evidence of Mitral Valve Disease

What are the possibilities? I think that she probably had mitral valve disease. I think she had hyperthyroidism, but I think you will just have to dismiss that. I don't believe she is one of these apathetic storm cases in which the patient instead of having hyperthermia, the circulatory changes of classical storm, just trails off in a vascular collapse. I wonder if she had unilateral pulmonary artery thrombosis. Mitral stenosis is one of the commoner causes of pulmonary artery thrombosis.

But multiple pulmonary emboli and pulmonary artery thrombosis do not make the left atrium big, and without any murmurs what's funny about her mitral valve lesion? Why doesn't she have them? Maybe she has a heavily calcified valve and does not have an opening snap as a result. Still, she should have a rumble, although occasionally a patient does not. What other things can do this? A masked thrombus in the left atrium can slowly work over the mitral valve and cause a decrease in the size of the orifice, but this is always secondary to mitral valve disease. If you see calcification of the left atrium you know you have clot on the wall in the atrium, but you also know you have mitral valve disease because it is rare to have a masked thrombus. Some-

body who reviewed the literature on this said that they found no case with a masked thrombus in the left atrium that did not have underlying mitral valve disease on a rheumatic basis.

Could she have a ball-valve thrombus? She did not have this thing slipping in and out and have the picture that you see in some myxomas, so I would suppose that she did not have this type of pedunculated thrombus or tumor. Although it is possible that this could be due to a myxoma with slow encroachment on the mitral valve, I would prefer to think that she had rheumatic heart disease with mitral valve disease and thrombosis in the left atrium, that the thrombus encroached further on the lumen, and that in addition she had multiple emboli and possibly even pulmonary artery thrombosis on that side.

DR. FREIMANIS: I would like to add just a little bit. As far as long-standing mitral stenosis is concerned, I do not see any good evidence of heavy calcification. This does not completely negate mitral stenosis but makes it less likely.

CLINICAL DIAGNOSIS

1. Rheumatic heart disease with involvement of the mitral valve.
2. Thrombosis of the left atrium.
3. Congestive heart failure.
4. Multiple pulmonary emboli.
5. Possible thyrotoxicosis.

PATHOLOGICAL DIAGNOSIS

1. Myxoma of the left atrium.
2. Cor pulmonale.
3. Hemorrhagic infarction of the lungs.
4. Hemorrhagic infarctions of the adrenals.

PATHOLOGICAL DISCUSSION

DR. SCARPELLI: We are presenting this case to show how a disease can be so masked that everybody completely overlooks it. I think in this case it was the woman's thyroid difficulty.

The body was that of a tall, undernourished white woman. The veins of the head, neck and upper chest were engorged. The abdomen was moderately distended. There was no evidence of generalized peripheral edema. The pleural cavities contained a total of 1000 cc. of yellowish-tan fluid. The left pleural cavity was partially obliterated by fibrous adhesions. The heart weighed 335 Gm. and was flabby. The right ventricle was marginally hypertrophied. The cardiac chambers were slightly dilated; this was mainly limited to the right ventricle and left atrium. The foramen ovale was anatomically closed.

Attached to the left atrial surface of the interatrial septum was a sessile, multilobulated mass of soft, grayish-yellow, gelatinous material measuring 7 by 5 by 6 cm. which almost completely filled the left atrium. Its attachment to the endocardium was broad, measuring 9 cm. The edges of the leaflets of the mitral valve and the chordae tendineae were slightly thickened, without shortening or fusion. The other valves were thin and pliable. The myocardium was tan and showed focal areas of subendocardial scarring in the left ventricle. The coronary arteries were thin-walled and pliable.

Both lungs were heavy and bluish-purple and on cut surface were firm and in the periphery showed discrete areas of darker discoloration. Hemorrhagic foamy fluid exuded on pressure. No thrombi or emboli were identified in the main pulmonary vessels or their smaller branches. The spleen showed a well-delineated, firm, yellow area measuring 2.5 cm. The adrenals were enlarged and hemorrhagic, and the adrenal veins appeared thrombosed. The kidneys were of normal size and showed multiple irregular yellowish-red areas in the cortex measuring up to 1 cm.

On *microscopic examination* the intra-atrial mass was seen to be composed of a loose myxomatous stroma containing stellate and multinucleated mesenchymal cells and numerous large blood vessels. The point of attachment showed chronic inflammation with granulation tissue and endarteritis with recent thrombosis of small vessels. The myocardium showed small patchy areas of subendocardial fibrosis. The lungs contained numerous hemosiderin-laden macrophages and showed sclerosis of capillary and arteriolar walls with occasional thromboses. Focal areas of recent infarction were also present. The spleen and kidneys also showed several areas of recent infarction. The architecture of the adrenals was completely disrupted by massive hemorrhage and infarction. The central veins were occluded by recent thrombus. The thyroid gland showed dilated follicles lined by flattened cells and filled with colloid.

From the findings at autopsy we can conclude that the patient was suffering from a myxoma of the left atrium with right ventricular hypertrophy. It is noteworthy that although the tumor encroached upon the mitral opening, since it was not pedunculated it did not produce ball-valve effects, and thus Dr. Leonard was led away from the diagnosis of ball-valve thrombus. Her disease was complicated by a nonspecific myocarditis and multiple thrombi affecting the lungs, spleen, kidneys and adrenals. The origin of the thrombi was probably the loose, shaggy layers of fibrin which covered the surface of the myxoma. There was no histological evidence of thyrotoxicosis, although her history and findings were strongly suggestive of it.

*In summary,* this was a case of myxoma of the heart with cor pulmonale and thrombotic microangiopathy. Her death may be attributed to a combination of right heart failure and adrenal failure.




# NEWS AND Organization Section

# Proceedings of The Council

## Suggest Payment-in-Full Plan Formulated for Study By Various Medical Groups; Other Important Actions Taken

A REGULAR meeting of The Council of the Ohio State Medical Association was held at the Granville Inn, Granville, Ohio, September 21, 22, 23, 1962. Those in attendance included all members of The Council, except Dr. Benjamin C. Diefenbach, Councilor of the Seventh District; all AMA delegates and all AMA alternate-delegates; Dr. Ralph W. Dwork, Columbus, Ohio Director of Health; Dr. Perry R. Ayres, Columbus, editor of *The Ohio State Medical Journal;* Dr. Charles L. Hudson, Cleveland, a member of the Board of Trustees of the AMA; Dr. Anthony Ruppersberg, Jr., Columbus, chairman of the Committee on Maternal Health; Dr. Harve M. Clodfelter, Columbus, president of Ohio Medical Indemnity, Inc.; Dr. R. Dean Dooley, Columbus, director of professional relations, OMI; Mr. Charles H. Coghlan, executive vice-president of OMI; Mr. Frank W. Van Holte, assistant treasurer of OMI; and members of the OSMA administrative staff.

### Minutes Approved

Minutes of the meetings of The Council held on July 14-15, 1962 were approved by official action.

### President's Advisory Committee

During his introductory remarks Dr. Hamwi, the president, said he felt that it might be helpful to him if he could name an advisory committee to assist in planning for future programs and projects for the Association. By official action The Council authorized Dr. Hamwi to name such an ad hoc committee.

### Membership Statistics

Following reports by members of The Council, the Executive Secretary presented membership statistics showing OSMA membership as of September 20 as 9,547, compared to a total membership at the end of 1961 of 9,530. The report also stated that of the 9,547 OSMA members, 8,606 were affiliated with the AMA.

### Proposed Payment-in-Full Plan

The Council then considered information from Ohio Medical Indemnity and other sources as to provisions for the proposed payment-in-full plan of the Ohio State Medical Association, authorized last May by the House of Delegates. A tentative proposal was formulated and by official action The Council authorized submission of the tentative proposal to the Ohio Academy of General Practice and to the medical specialty groups in the state. These groups will be asked to review the tentative program and to offer advice and suggestions concerning it. Reports received from the various groups will be reviewed by The Council or a special insurance committee. It was felt that a three months' deadline should be given for receiving replies. Also The Council decided that a communication should go to the county medical societies at the time the tentative proposal is sub-

mitted to the above-named groups so the county societies will be kept up to date on all activities with regard to this question.

### Billings by Hospitals

Following a discussion by Mr. Coghlan of some of the problems which confront Ohio Medical Indemnity in connection with services rendered in a hospital and billed by a hospital, The Council made the following recommendation to Ohio Medical Indemnity:

That Ohio Medical Indemnity insert in all of its new contracts a stipulation that benefits shall be payable only when the services are rendered and billed by a physician; that existing contracts which do not carry this provision should be amended accordingly as quickly as possible; that OMI officials confer with the Blue Cross Plans of Ohio regarding a plan whereby coverage for professional services performed in a hospital or in the hospital out-patient department should be transferred from Blue Cross to Blue Shield.

### AMA Delegates

Dr. George A. Woodhouse, Piqua, reported on a meeting of the AMA delegates and alternates held on Friday night, September 21. He reported that delegation officers had been elected as follows: chairman, Dr. Woodhouse; vice chairman, Dr. George W. Petznick, Cleveland; and that a special committee consisting of the chairman, vice chairman, Dr. Edmond K. Yantes, Wilmington, and Dr. Edwin H. Artman, Chillicothe, had been named to draft a plan for the organization of the delegation and for the drafting of a statement outlining the functions and policies of the delegation.

Dr. Woodhouse also reported on arrangements which had been made for a hospitality suite and for a breakfast for the delegates at the forthcoming interim session.

### Report of Committee on Scientific Work

Mr. Page reported for the Committee on Scientific Work, the report being based on minutes of the meeting of the committee held on August 26, 1962.

The recommendations of the committee concerning the schedule of events for the 1963 Annual Meeting at the Sheraton-Cleveland Hotel the week of May 12 were approved.

Suggestions regarding the program for the Tuesday morning general session were offered by members of The Council.

By official action The Council decided that the major social event of the 1963 Annual Meeting should be a president's reception from 6 to 8 p. m. on the evening of May 15, consisting of a cocktail party, music and dancing.

### Report of Committee on Care of the Aged

A report on a meeting of the Committee on Care of the Aged, held on September 16, was presented by Dr. P. John Robechek, Cleveland, chairman of that committee. The report consisted of voluminous information regarding the finances and budget for the Division of Aid for the Aged. The committee's recommendation to The Council, that it approve the following statement, was adopted by The Council and the report of the committee as a whole was approved:

"That the Ohio State Medical Association approves the action of the Medical Advisory Committee to the State Division of Aid for the Aged in supporting the contemplated request of the Division for adequate appropriations with which to employ additional necessary personnel for Division activities and for more adequate compensation for case workers and other key personnel; also approves the action of the Medical Advisory Committee in recommending increases in the medical and surgical fee schedule used by the Division."

### Report of Committee on Maternal Health

Dr. Ruppersberg presented a report for the Committee on Maternal Health. The report was approved by The Council and the publication of the annual report of the committee in *The Ohio State Medical Journal* was authorized.

### Report of Committee on Disaster Medical Care

A report of the Committee on Disaster Medical Care, based on a meeting of that committee held on September 9, was presented for Council consideration and discussed by Mr. Traphagan, seceretary of the committee. The report was approved by official action.

### Report of Committee on Medicine and Religion

Mr. Traphagan gave an oral report on a recent meeting of the Committee on Medicine and Religion. The report also was discussed by Dr. Petznick, chairman of that committee. Actions of the committee were approved.

A report on the forthcoming Congress on Mental Illness and Health on October 4, Chicago, sponsored by the AMA was presented by Mr. Traphagan. The report covered activities of the Ohio delegation which will consist of approximately 80 persons from Ohio.

### Rural Medical Scholarship

Mr. Edgar reported on the meeting of the Rural Medical Scholarship Subcommittee, stating that the committee had selected Mr. Wesley W. Hiser, Ludlow Falls, Route 1, Miami County, Ohio, as the winner of the 1962 scholarship. Mr. Edgar stated that information from the AMA indicated that the AMA probably will hold the 1963 Rural Health Congress in Columbus in April of that year.

### Reports on District Legislative Meetings

Detailed reports on the district legislative meetings which have been held to date and those planned



*Shown above are members of The Council, AMA Delegates and Alternates and others who attended the Granville meeting. Seated, left to right:* RALPH E. DWORK, *Director of the Ohio Department of Health;* GEORGE A. WOODHOUSE, *Past-President and AMA Delegate;* PHILIP B. HARDYMON, *Treasurer and Alternate Delegate;* H. T. PEASE, *President-Elect and Alternate Delegate;* GEO. J. HAMWI, *President;* GEORGE W. PETZNICK, *Immediate Past-President and Delegate;* CHARLES L. HUDSON, *OSMA Past-President and member of the AMA Board of Trustees;* EDWIN H. ARTMAN, *Past-President and Alternate Delegate.*

*Standing, left to right:* MR. GEORGE H. SAVILLE, *OSMA Director of Public Relations;* ROBERT C. BEARDSLEY, *Eighth District Councilor;* GEORGE J. SCHROER, *Second District;* CHESTER H. ALLEN, *Ninth District;* T. L. LIGHT, *Alternate Delegate;* LAWRENCE C. MEREDITH, *Eleventh District;* FREDERICK P. OSGOOD, *Chairman of the OSMA Committee on Professional Relations and Alternate Delegate;* E. R. MURBACH, *Fourth District;* J. ROBERT HUDSON, *Alternate Delegate;* ROBERT E. TSCHANTZ, *Sixth District;* MR. CHARLES S. NELSON, *OSMA Executive Secretary;* HENRY A. CRAWFORD, *Fifth District;* JOHN H. BUDD, *Delegate;* ROBERT E. HOWARD, *First District;* HARRY K. HINES, *Alternate Delegate;* ANTHONY RUPPERSBERG, JR., *Chairman of the OSMA Committee on Maternal Health;* FLOYD M. ELLIOTT, *Third District;* PAUL F. ORR, *Chairman of the Committee on Hospital Relations and Delegate; and* CHARLES A. SEBASTIAN, *Delegate.*

*Present at the meeting but not shown in the picture were Carl A. Lincke, Delegate; Robert S. Martin, Chairman of the Ohio AMA-ERF Committee and Alternate Delegate; Richard L. Meiling, Delegate; Edmond K. Yantes, Delegate; P. John Robechek, Chairman of the OSMA Committee on Care of the Aged and Alternate Delegate; Harve H. Clodfelter, President of Ohio Medical Indemnity; R. Dean Dooley, OMI Director of Professional Relations; Messrs. Charles H. Coghlan and Frank W. Van Holte, of the OMI staff; also Messrs. Hart Page, Charles Edgar, Mike Traphagan and Gordon Moore of the OSMA staff.*

for the future were given by Dr. Hamwi and Mr. Saville.

### Institute on High School Athletics

A report on the recent Post-Graduate Institute for Physicians on Medical Aspects of High School Athletics, of which the OSMA was a co-sponsor, was presented by Mr. Page.

### Report on AMA Institute, Chicago

Mr. Edgar and Mr. Traphagan reported on the recent AMA Institute held in Chicago and sponsored by the AMA.

### Report by Ohio Director of Health

Dr. Dwork discussed the current Sabin polio situation and commented on some of the legislative proposals which probably will come before the Ohio General Assembly when it convenes in 1963.

### State Services for Crippled Children

A letter from the Ohio Society of Physical Medicine and Rehabilitation regarding certain rules and regulations of the State Services for Crippled Children, which in the opinion of that society restrict the privileges of physiatrists, was read and discussed. The communication was referred to the Committee on Public Relations and Economics for review, with a recommendation that it confer with all parties concerned in an effort to try to work out a solution.

### Community Service Award

A letter from the A. H. Robbins Company, Inc., asking the Ohio State Medical Association to initiate

a community service award project was discussed. It was the opinion of The Council that such a project should not be initiated at this time.

### Report on Grievance Activities

The Executive Secretary presented a report on questionnaires received to date from the county medical societies on grievance activities. He urged members of The Council to try to get reports on missing counties in as soon as possible so that the Judicial and Professional Relations Committee can start to work on this question.

### Report on 1962 AMA-ERF Campaign

Mr. Saville presented a report on plans for the 1962 AMA-ERF campaign in Ohio.

### Veterans Administration Fee Schedule

The Council voted to request the Veterans Administration to make increases in the following fees: Cardiac examination, including electrocardiogram, from $15.00 to $25.00; X-ray of chest, PA and lateral, with report, from $10.00 to $15.00.

### Fifty-Year Awards

The fifty-year certificates and gold emblems were given out to the Councilors for them to arrange for presentations with their respective county medical societies.

### Mahoning County Amendments Approved

Amendments adopted by the Mahoning County Medical Society to its Code of Regulations on September 18, revising the wording and provisions of Chapter 5, Section 1, of the Code of Regulations of that society, were officially approved.

### County Society Officers Conference

It was decided to hold the annual conference of county medical society officers and committeemen at the Fort Hayes Hotel, Columbus, on Sunday, March 3, 1963.

### Dates of Future Meetings

Dr. Hamwi asked for suggestions as to the date of the next Council meeting and it was agreed that the next meeting should be held on Sunday, November 11.

Dr. Hamwi announced that the Committee on Auditing and Appropriations would meet on Sunday, December 9, and that the December meeting of The Council would be held on Saturday afternoon and Sunday, December 15 and 16.

He announced that members of The Council and delegates and alternates should secure their own hotel accommodations for future meetings of The Council inasmuch as some have preferences for certain hotels or motels.

Before adjourning The Council decided that the annual Fall meeting of The Council should be held in the Columbus area in 1963.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
*Executive Secretary*

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## Nurse License Must Be Kept Current By Renewal

Employers of nurses and registries should make an annual check of the current registration or licensure status of nurse employees or registrants, and should check also the current registration or licensure status of each applicant, according to the State Board of Nursing Education and Nurse Registration.

Every nurse who is currently registered or licensed in Ohio has been issued evidence of her current registration or licensure, and should be required by her employer to show this evidence. Special note should be made of the expiration date. An expired license is not valid. Any nurse claiming to be registered or licensed in Ohio who cannot produce current Ohio licensure credentials should be reported to the Board.

Practical nurses currently licensed to practice in Ohio as licensed practical nurses for the 1962-63 renewal period, have been issued their renewal licenses for this period effective September 1. The color of the 1962-63 license is **pink**, with the date of expiration August 31, 1963. Anyone practicing as a licensed practical nurse without a valid 1962-63 license, is practicing illegally and is subject to the penalties of Section 4723.99 of the Revised Code of Ohio.

The professional nurse renewal applications for 1963 will be mailed the middle of November. Ohio law requires that the professional nurse file her 1963 renewal application and $2.00 fee by January 1, 1963. The 1962 certificate will expire February 28, 1963. The 1963 certificates, which will be **natural** in color, will be mailed to professional nurses the middle of February.

A nurse—professional or practical—who has been originally registered or licensed in another state or country, cannot legally practice as a registered nurse or licensed practical nurse in Ohio unless she holds an Ohio certificate of registration or license. Upon employment, she should be required **immediately** to apply for registration or licensure in Ohio. **There is no provision in the Ohio law for a 6 months period of grace before making application. There is no such thing as a temporary permit in Ohio.**

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A $300,000 two-year public service project to make animal tests on dyes that give drugs their identifying colors has been undertaken by the prescription drug industry. Financed by 26 member firms of the Pharmaceutical Manufacturers Association, the program will test seven key colors.

# OSMA ANNUAL MEETING and

## All Events under One Roof in the New Sheraton-Cleveland

**General Information:** The entire meeting of the Ohio State Medical Association May 12-17, 1963, will be under one roof . . . using the new exhibit hall, grand ballroom and the remodeled facilities of the Sheraton-Cleveland Hotel in Cleveland.

**House of Delegates:** A dinner, and opening business session of the House of Delegates will be held at 6 p. m., Sunday, May 12. Resolutions Committees will meet all day Monday, May 13, and Tuesday morning, May 14, if necessary. Final session of the House of Delegates, with election of officers for 1963 and final action on resolutions and policy matters, will be held at 9 a. m., Wednesday, May 15.

**Specialty Societies:** Most of the specialty societies in Ohio will hold meetings during the week. Most of them will combine with the Specialty Sections of the Ohio State Medical Association in presenting scientific programs for all OSMA members. They also will hold their own business and social events.

**Heart and Cancer Programs:** A General Session on cancer will be presented at 2 p. m., Tuesday, May 14, by the Ohio Division, Inc., American Cancer Society. A General Session on heart disease will be presented at 2 p. m., Wednesday, May 15, by the Ohio State Heart Association.

**Fireside Conferences:** The American College of Chest Physicians and its Ohio Chapter will again this year present the informal fireside conferences at the 1963 meeting. Scheduled for 8 p. m., Thursday, May 16, these sessions will be round table discussions by "experts" who will discuss questions on diagnosis and treatment of cardiopulmonary diseases and many other conditions of interest to all physicians. Those attending can move from table to table as they wish. Refreshments will be served.

**"How I Do It":** An all new feature for 1963 will be the "How I Do It" sessions Thursday morning. Experts will tell how they do bone marrow biopsy and an emergency tracheotomy; how they deal with nasal hemorrhage, and with small bowel obstruction; how they handle status asthmaticus, brittle diabetes, and a lump in the breast.

**"What's New?":** Again in 1963 a general session on "What's New?" will be a popular part of the meeting. This session will be held on Thursday morning, May 16.

**Social Events:** The President's Reception, a new Annual Meeting feature, will be held at 6 p. m., Wednesday, May 15, for members attending the meeting.

**ALL EVENTS WILL BE ON EASTERN DAYLIGHT SAVING TIME**

# POSTGRADUATE ASSEMBLY

## Schedule of Events for OSMA Meeting May 12-17 in Cleveland

### SUNDAY, MAY 12

6:00 P. M.

Dinner and business session, House of Delegates.

### MONDAY, MAY 13

9:00 A. M. to 5:00 P. M.

Meetings of Resolutions Committees.

### TUESDAY, MAY 14

9:00 A. M.

Registration Opens.

Opening of Exhibits.

10:00 A. M.

General Session.

"The Right to Die"

Edward H. Rynearson, M. D., Mayo Clinic, Rochester, Minnesota.

2:00 P. M.

General Session.

Program to be presented by the Ohio Division, Inc., American Cancer Society.

### WEDNESDAY, MAY 15

9:00 A. M.

Registration.

Opening of Exhibits.

9:00 A. M.

Final session of the House of Delegates.

10:00 A. M.

General Session.

Medical motion picture program, hospital clinics and ward rounds.

2:00 P. M.

General Session.

Program to be presented by the Ohio State Heart Association.

6:00 P: M.

President's Reception.

### THURSDAY, MAY 16

9:00 A. M.

Registration.

Opening of Exhibits.

9:30 to 10:30 A. M.

General Session.

"What's New?"

1. Salk or Sabin Vaccination?
2. The Calibration of the Technician
3. Surgery for Deafness
4. Treatment of Toxemia
5. Surgical Treatment of Bleeding Peptic Ulcer
6. Tetanus Immunization and Prophylaxis

10:30 to 11:00 A. M.

Recess for Tour of Exhibits.

11:00 A. M. to 12 Noon

General Session

"How I Do It"

1. Bone Marrow Biopsy
2. Emergency Tracheotomy
3. Nasal Hemorrhage
4. Small Bowel Obstruction
5. Status Asthmaticus
6. Brittle Diabetes
7. A Lump in the Breast

2:00 to 5:00 P. M.

Sessions of Scientific Sections and Specialty Societies:

Sections on Anesthesiology, General Practice, and Occupational Medicine (combined session)

Section on Internal Medicine and the Ohio Society of Internal Medicine

Section on Obstetrics and Gynecology

Section on Ophthalmology and the Ohio Ophthalmological Society

Section on Otorhinolaryngology

Conference on Laboratory Medicine.

3:30 to 5:00 P. M.

Ohio Chapter, American College of Chest Physicians.

8:00 P. M.

Fireside Conferences.

To be presented jointly by the Ohio Chapter of the American College of Chest Physicians and the Ohio State Medical Association.

### FRIDAY, MAY 17

9:00 A. M.

Registration.

Opening of Exhibits.

*(Continued on Next Page)*

## Annual Meeting (Contd.)

**9:30 to 10:30 A. M.**

Ohio Neurological Society.

Section on Nervous and Mental Diseases and Ohio Psychiatric Association.

General Session.

Program to be presented by the Western Reserve University School of Medicine.

**10:30 to 11:00 A. M.**

Recess for Tour of Exhibits.

**11:00 A. M. to 12:00 Noon**

Continuation of General Session program.

**1:30 P. M.**

Session of Scientific Section:

Section on Pathology and the Ohio Society of Pathologists.

**2:00 to 5:00 P. M.**

Sessions of Scientific Sections:

Section on Nervous and Mental Diseases and the Ohio Psychiatric Association

Section on Neurological Surgery and the Ohio Neurosurgical Society

Section on Pediatrics and the Ohio Chapter, American Academy of Pediatrics

Section on Physical Medicine and the Ohio Society of Physical Medicine and Rehabilitation

Section on Radiology

## Medical Care Rise Is Led By Hospital Insurance

The Department of Labor's quarterly breakdown of the components of medical care category in the consumer price index discloses the bullish influence of hospitalization insurance. As of last June 30, premium rates in the larger cities averaged 36.6 per cent higher than the base period (1957-1959) average. By comparison, physicians' fees were only 11.9 per cent higher and dentists' fees 8 per cent. Also considerably larger than other components were inpatient hospital charges, which were 29.4 per cent above 1957-59.

In the meantime, prices of prescriptions and over-the-counter drugs have gone down in the past two years. In the Bureau of Labor Statistics tables, these declines range from 2 per cent for anti-spasmodics and anti-arthritics to 12 per cent for anti-infective drugs. In the drug grouping, the only items with higher price indices are milk of magnesia and aspirin.

## Allergy Meeting

American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress. March 24 - 29, 1963, Americana of New York, New York City. For further information, write to: John D. Gillaspie, M. D., Treasurer, 2141 14th Street, Boulder, Colorado.

## Explanation of FTC Letter To Physicians

Recently many Ohio physicians received from the Federal Trade Commission a copy of "Trade Practice Rules for the Optical Products Industry," and an accompanying letter inviting the addressee to file an enclosed card indicating voluntary compliance.

The Commission has declared by its definition of 'Optical Products Industry' that a physician supplying prescription eyeglasses or lenses of any kind (including contact lenses) is a member of the Optical Products Industry.

A physician who does not supply any lenses, contact lenses or other optical prostheses, or spectacles to patients under any circumstances, is not a member of the Optical Products Industry by the FTC definition, and the letter requesting compliance does not apply to him.

A physician who does supply lenses, contact lenses or other prostheses, or spectacles to patients is covered by the FTC Communication.

A physician who does not sign and file 'intent to observe' the rules is not violating the rules or the law, or indicating any intention to violate any rule or to violate the law. The signing of the statement is an entirely voluntary act.

## Court Holds Druggist Can Be Sued for Malpractice

In a recent case in Hamilton County (Boudot v. Schwallie), the Court of Appeals held that a pharmacist can be sued for malpractice. In the case at issue, the court stated "It is clear to this court that the plaintiff, by her allegations, places the defendant in the category of a professional acting unskillfully within the framework or branch of the practice of medicine. The doctor relies upon the pharmacist for the specific medication prescribed for his patients. The practice of the profession of pharmacy is a part and parcel of the system of practice of modern medicine.

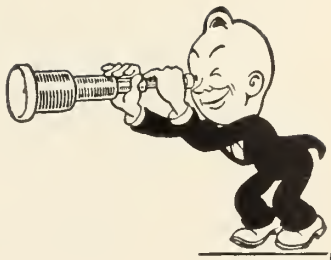
The case was won by the defendant druggist because the case was not filed within one year under the statute of limitations.

## Women Physicians To Meet In Los Angeles

The American Medical Women's Association will hold a scientific session and House of Delegates meeting at The Ambassador in Los Angeles on November 29 and 30, following the American Medical Association session (November 25-28).

Women physicians interested in details of the program may write to the American Medical Women's Association, Inc., 1790 Broadway, New York 19, New York.

# *Looking Ahead . . . . .*



## Hotel Reservations

## Are Now in Order

**For the 1963 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION. Assure yourself and party excellent accommodations by filling out the coupon below NOW and mailing it to the hotel of your choice. The place is CLEVELAND: the dates. MAY 12 - 17. 1963.**

| NAME AND LOCATION | SINGLE | DOUBLE | DOUBLE TWIN BEDS |
|---|---|---|---|
| SHERATON-CLEVELAND HOTEL, Public Square (Headquarters Hotel) | $7.85-15.50 | $11.85-17.50 | $14.00-21.00 |
| AUDITORIUM HOTEL, 1315 East 6th St. | 5.50-10.00 | 8.50-12.50 | 12.50-13.50 |
| PICK-CARTER HOTEL, Prospect & E. 9th St. | 6.50-12.00 | 10.50-16.00 | 12.00-16.00 |
| STATLER HILTON HOTEL, Euclid & E. 12th St. | 6.50-14.50 | 13.00-16.00 | 14.00-30.00 |

Persons who desire additional accommodations are advised to specify their needs to the hotels of choice.
(All Rates Subject to Change)

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HOTEL RESERVATION BLANK
Mail the coupon to hotel selected

Manager _____ (Name of Hotel) , Cleveland, Ohio

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 12-17, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price

☐ Twin Bed Room with Bath ☐ Suite

Arriving May ____ at ____ A. M. ____ P. M. .

PLEASE VERIFY MY RESERVATION

Name

Address

# Jenkins-Keogh Bill Becomes Law . . .

## Measure is Designed to Give Self-Employed Persons Tax Break in Setting Up Pension-Retirement Plans

AFTER undergoing about 10 years of revision, debate and controversy, the so-called Jenkins-Keogh Bill is now a law. The measure, first introduced into Congress some 10 years ago by the late Congressman Thomas Jenkins of Ohio, was enacted by Congress by an overwhelming vote and signed by President Kennedy on October 10. The only Ohio members of Congress voting against the bill were Senators Young and Lausche. The new law will permit physicians, dentists, lawyers and many other self-employed persons to claim a tax deduction for contributions made by them to pension and retirement plans. As passed, the bill is tightened up considerably from the original proposal. For that reason careful analysis of the new law by legal and tax authorities representing self-employed persons will be necessary before definite plans can be set up.

### Highlights of Law

Highlights of the much-revised measure which extends to self-employed some of the favorable tax benefits present law now provides in the case of qualified retirement plans established by employers for their employees are as follows:

### Coverage

Coverage would be extended to all persons now subject to the self-employment tax, and in addition, to physicians and clerics; also to owner-employees who are engaged in trade or business in which both personal service and capital are material income-producing factors but where the individuals actually render personal services on a full-time, or substantially full-time basis; and to employees of self-employed persons, through contributions made for them by their employers. (If a self-employed individual desires retirement income coverage for himself he must cover all of his employees, except part-time employees, who have worked for three years or longer.)

### Contributions

Contributions to such self-retirement plans may amount to $2,500 or 10 per cent of earned income, whichever is less; but only one half of the actual contribution for the benefit of the self-employed, up to a maximum of $1,250, would be deductible from taxable income. Thus, if say 10 per cent of an individual's earned income from personal services is $2,000, then the amount allowed as a deduction would be one-half of that sum, or $1,000; the other $1,000 of contribution would not be allowed as a deduction.

### Funds

Funds contributed may be placed under trust in a bank or under contract with an insurance company. A plan could be established, with or without a trust, solely for the purchase of a new type of Government bond, the proceeds of which would be taxable upon redemption. Also a custodial account in a bank could be established; it would be treated as a qualified trust if used for the investment of the funds (a) solely in regulated investment company stock of which an employee would be the beneficial owner; or (b) solely in annuity, endowment, or life insurance contracts issued by an insurance company.

### Special Provisions

Special provisions which must be incorporated in self-retirement plans include the following:

Employees' rights become fully vested and nonforfeitable at the time contributions are made.

No benefits can be paid on behalf of an owner-employee before age 59½, except on account of permanent disability.

The entire interest of each employee either will be distributed to him at age 70½, or in the case of an employee other than an owner-employee, when he retires, whichever is the later; or, commencing not later than age 70½, will be distributed over a period not extending beyond the life expectancy of the employee or his spouse.

Upon the death of an owner-employee, his interest would have to be distributed within 5 years, or used within that period to purchase an immediate annuity for his beneficiary, except if distribution has commenced for a term certain over a period not extending beyond the life expectancy of the owner-employee and his spouse.

### Effective Date

Effective Date: Provisions of the bill would apply to taxable years beginning after December 31, 1962. Thus, the prospect is that self-employed persons who are interested in establishing a self-retirement plan will have until the late weeks of 1963 to decide how best to do it; and to determine how much to contribute to such a plan, based on income earned in the year.

# APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1963 ANNUAL MEETING, SHERATON-CLEVELAND HOTEL, CLEVELAND, OHIO, MAY 12-17

1. Title of Exhibit: _____

2. Name(s) of Exhibitor(s): _____

_____

Institution (if desired): _____

City _____

3. Do you have a built-in exhibit? _____

4. Description of Exhibit: **(Attach 200 word description to this blank)**

5. Exhibit will consist of the following: (Check which)

Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

Specimens _____ Moulages _____ Other material _____
(Describe)

6. Booth Requirements:

Amount of wall space needed? _____

Back wall _____ Side walls _____

Square feet needed? _____

Shelf desired? (yes or no) _____

7. Transparency Cases:

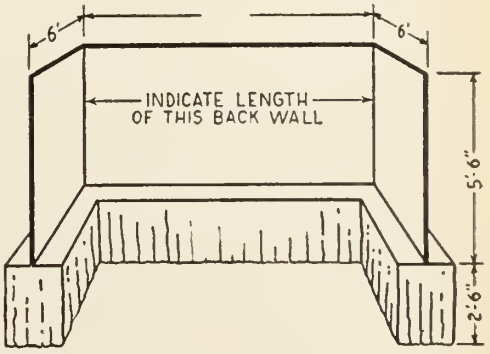
Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____

_____

_____




*Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.*

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association" which will be supplied to all applicants.

Date _____

_____
Signature of Applicant

_____
Mailing Address, Street

_____
City, Zone, State

**SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO.**
**DEADLINE FOR FILING APPLICATIONS, FEBRUARY 15, 1963**

# Taxpayer-Identifying Numbers . . .

## Account Number in Lieu of Social Security Number Necessary for Federal Tax Purposes in the Future

THE installation by the Internal Revenue Service of an automatic data processing system which uses modern high-speed electronic equipment necessitates the use of numbers in addition to names to identify taxpayers in electronic and other records. In order to give effect to this new system, Congress enacted legislation last year providing for taxpayer-identifying numbers on Federal tax returns and related documents, effective for the tax year 1962 and thereafter. And, in this connection, Congress authorized the Commissioner of Internal Revenue to prescribe regulations requiring taxpayers and payers of income to obtain and use identifying numbers. Such regulations have, in fact, recently been adopted. These regulations are highlighted in the following, prepared by the Law Department of the AMA.

### Legal Requirement

The Commissioner of Internal Revenue, on August 24, 1962, adopted regulations requiring taxpayers and payers of income to obtain and use identifying numbers. The regulations term the number prescribed for use by an individual an "account number." Since 140 million Americans already have Social Security numbers, it was decided to use these numbers to avoid the inconvenience of obtaining other numbers.

Unless a physician is or was ever an "employee," it is unlikely that he will have a Social Security number since doctors of medicine who are self-employed are excluded from coverage under the Social Security system.

However, since every person required to make a return, statement, or other document for any period commencing after 1961 with respect to his tax liability, must have an account number, physicians will have to obtain such numbers even though they are not covered under the Social Security system.

### Number Required for 1963

According to the regulations, application forms for use in obtaining account numbers will as far as possible be furnished without request during 1962 to taxpayers needing numbers. Thus, a taxpayer is not required to file an application for an account number during 1962 unless furnished with an application. A taxpayer who has been supplied with an application form must file it in accordance with the instructions for such form. After 1962, an individual needing an account number must file an application for an account number on either Form SS-5 or Form 3227. An application form may be obtained from any District Director, or any District Office of the Social Security Administration.

An individual engaged in a trade or business is also required to obtain an identifying number which is termed an "employer identification number." For this (an our) purpose, an individual is considered to be engaged in a trade or business if any return is required to be filed by him as an employer (other than a household employer) with respect to his liability for the Social Security taxes imposed under the Federal Insurance Contributions Act and the provisions of the Internal Revenue Code which require an employer to withhold income taxes from the wages of employees. Thus, such an individual may not only have an account number but an employer identification number. And, under the regulations he is required not only to include his account number in the appropriate return, statement or other document but also to include his employer identification number in the schedule provided for reflecting profit or loss from a business or profession.

Obviously, a physician - employer is required to obtain an employer identification number if he doesn't already have one. This is unlikely if he has been an employer for some time. If a number has not been assigned then application therefore must be made on Form SS-4 to any District Director or any District Office of the Social Security Administration office. Referring to the requirement as to the inclusion of account numbers and employer identification numbers, a physician employer would have to include his ac-


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Education and Research Foundation
535 North Dearborn Street, Chicago 10, Illinois
AMA-ERF

count number on his income tax return, (or declaration of estimated income tax) and his employer identification number on Schedule C of Form 1040 (Profit (or Loss) from Business or Profession).

### If Spouse Has Income

An income tax return or a declaration of estimated income tax filed jointly by a husband and wife need include only the account number of the husband. However, a wife's account number must also be shown if, for the taxable year covered by the return or declaration, the wife has (a) separate gross income of $600 or more, or $1,200 or more if she has attained the age of 65 before the close of the taxable year, (b) self-employment income, or (c) income (such as wages, dividends, or interest) paid to her otherwise than with her husband which the payer thereof is required to report on a return or statement of information.

The law and regulations impose a penalty for failure to include the identifying number in any return, statement, or other document, or when otherwise required. The penalty is $5 for each such failure.

## Cultural Seminars Resumed In Mahoning County

The Mahoning County Medical Society will conduct its third annual Cultural Seminar for Physicians, beginning on Thursday evening, November 8.

Based on the two previous programs, a series of twelve lectures will be presented in cooperation with Youngstown University on the subjects of literature, music and art.

Christine Dykema of the Youngstown University Departments of French and English will give the opening four lectures on literature on successive Thursdays with one week off for Thanksgiving. The lectures will resume after the first of the new year with Rev. W. Frederic Miller of the University Dana School of Music giving four lectures on music. The concluding four lectures on art will be given by George Faddis of the Butler Art Institute.

Chairman for the seminar for the medical society is Dr. Frank Gelbman. Dr. Clair L. Worley, Ph.D., chairman, Department of Biology, manages the seminar for the University. All meetings are held at St. Elizabeth Hospital Auditorium. Doctors and their wives are invited. Interns, residents, and their wives, are guests of the Mahoning County Medical Society.

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The West Virginia State Medical Association at their annual meeting in White Sulphur Springs elected a former member of the staff of the department of Ophthalmology of the Ohio State University College of Medicine, Dr. Albert C. Esposito, as its new vice-president.

## Dr. Annis To Address Cleveland Joint Medical-Legal Meeting

Dr. Edward R. Annis, President-Elect of the American Medical Association and well-known spokesman for the medical profession, will be guest speaker when the Academy of Medicine of Cleveland and the Cleveland Bar Association meet on December 10.

This joint meeting will be at the Hotel Manger beginning with a social period at 5:30 p. m. and dinner at 7:00, and an after-dinner program.

Reservations should be made with Robert A. Lang, executive secretary of the Academy of Medicine of Cleveland, 10525 Carnegie Avenue, Cleveland 6; or with Robert Kehoe, executive secretary of the Cleveland Bar Association, 1802 East 13th Street, Cleveland. A nominal charge will be made for dinner.

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## Accreditation Question About Osteopaths Clarified

In order to clarify a question as to whether a hospital having osteopathic physicians on its staff is eligible for accreditation by the Joint Commission on Accreditation of Hospitals, the Ohio State Medical Association recently sought the advice of Dr. Kenneth B. Babcock, director of the Joint Commission. Dr. Babcock stated that such hospital would be eligible for a survey for accreditation and would be accredited if it meets all accreditation requirements, providing it meets the following stipulation:

It must be accepted for listing by the American Hospital Association under the 1959 listing requirements of the AHA, reading in part as follows:

"Only doctors of medicine or doctors of osteopathy shall practice in hospitals listed by the American Hospital Association. (This requirement is not intended to eliminate dental and similar services from the hospital. Patients admitted for such services, however, must have an admission history and physical examination done by a physician on the staff of the hospital, and a physician on the staff of the hospital shall be responsible for the patient's medical care throughout his stay.)

"The hospital shall submit evidence of regular care of the patient by the attending physician and of general supervision of the clinical work by doctors of medicine.

"If doctors of osteopathy are practicing in the hospital, then, under the requirements for listing, the overall supervision of clinical work must be under a doctor of medicine (as chief of staff and chief of department, if departmentalized). There is no intention to divorce the attending physician, either M. D. or D. O. from his patient, but the supervision of the clinical activities of all practitioners must be conducted by a doctor of medicine."

# Medical Aspects of Athletics...

## Many Physicians Associated with Athletic Teams Attend Jointly Sponsored Workshop in Columbus

SOME 108 Ohio physicians participated in the second Postgraduate Institute on Medical Aspects of High School Athletics last August in Columbus. The Institute was oversubscribed by registration deadline, and a number of late applicants could not be accommodated.

Sponsored by the Ohio State Medical Association, The Ohio State University College of Medicine, and the Ohio High School Athletic Association, the purpose of the course was to provide the physician in practice with current concepts involved in the prevention and care of athletic injuries. A previous institute was held in 1960.

Sessions were held on the College of Medicine Campus, in the OSU Stadium Training Rooms, and in the St. John's Arena. A reception was held for speakers and participants.

Registrants were mostly high school team physicians, some were physicians for college athletic teams.

Subjects covered included: "On-The-Job Viewpoints of Medical Aspects of High School Athletics"; "Qualifications for Participation in Athletics"; "Medical Problems in Athletics"; "Field Decisions"; "Emotional Aspects of High School Athletics."

"Report of the High School Athletic Commissioner"; "The Physician As Trainer"; "Management of Common Athletic Injuries"; "Conditioning Drill and Blocking Techniques"; "Dental Protection"; "Contact Lenses" "Taping"; "Special Protective Equipment"; "Prevention of Head and Neck Injuries."

"Orthopedic Problems in Adolescence"; "Head Injuries"; and "Neck Injuries."

The institute committee included: Drs. Thomas E. Shaffer, Columbus, chairman; Charles H. McMul-



*This is part of the group that heard discussions on Medical Aspects of High School Athletics during the jointly sponsored institute on the Ohio State University campus.*

## Participants in Aspects of Athletics Institute



*Members of this panel on Orthopedic Problems in Adolescence are left to right, Drs. William E. Hunt, Martin P. Sayers, and Judson D. Wilson.*



*Following their respective talks, these speakers formed a panel to answer questions from the floor. Left to right are Angus E. King, moderator, at rostrum; Dr. Robert Murphy, Dr. Richard Patton, Ernest Biggs and Dr. Thomas Shaffer.*



*Here are four other principal participants in the Institute. Left to right, are Dr. R. H. Magnuson, Dr. John Prior, Dr. Allan Ryan, and W. W. (Woody) Hayes, head football coach at Ohio State University.*

len, Loudonville; Robert J. Murphy, Columbus, representing the OSMA Committee on School Health; and Dr. John A. Prior, assistant dean in charge of Continuing Education, OSU; Commissioner W. J. McConnel and Assistant Commissioner Paul E. Landis, Ohio High School Athletic Association, and Hart F. Page, OSMA.

Program participants included: Bron Bacewich, football coach, Roger Bacon High School, Cincinnati; Ernest R. Biggs, head trainer, OSU; Joseph L. Bitonte, instructor in ophthalomology, OSU; Dr. Geo. J. Hamwi, president of OSMA; W. W. Hayes, head football coach, OSU; Dr. William D. Heintz, associate professor, OSU College of Dentistry; Walter Heischman, superintendent of schools, Upper Arlington.

Dr. William E. Hunt, Columbus; Angus E. King, director of athletics, Cincinnati Board of Education; Dr. R. H. Magnuson, Columbus; Commissioner McConnell; Dr. McMullen; Dr. Richard L. Meiling, dean of the OSU College of Medicine; Dr. W. Hugh Missildine, Columbus; Dr. Murphy.

Dr. Richard Patton, Columbus; Dr. Prior; Dr. Allan J. Ryan, Meriden, Connecticut, past chairman of the AMA Committee on Medical Aspects of Sports; Dr. Martin P. Sayers, Columbus; Dr. Shaffer, and Dr. Judson D. Wilson, Columbus.

## New Booklet on Group Practice Released

"Group Practice," a new booklet which gives valuable pointers on the organization and establishment of a medical group, has recently been released by the Liaison Committe of the American Association of Medical Clinics, the American Medical Association and the National Association of Clinic Managers.

The booklet resulted from a meeting held in Chicago in February 1960, which concluded that there was a need for "a small but complete booklet" which could be made available by each of these organizations to physicians seeking information on methods of forming medical groups. Responsibility for writing the book was turned over to representatives of the three organizations.

This booklet considers many of the facets of group practice, including the following: factors and trends in development of group practice in the United States, forms and types of group practice, advantages and disadvantages of group practice, factors to be considered by the individual before *joining* a group, and factors to be considered by the individual before *forming* a group.

The booklet also considers the ethical and legal problems relating to group practice and the business management aspects of group practice organizations.

Copies of the booklet and further information concerning it may be obtained from the Council on Medical Service of the AMA, Chicago.

## Social Security Loses Money Treasury Report Shows

The Treasury Department's preliminary figures for fiscal year ended June 30, 1962, shows that the social security system lost 1 billion 248 million dollars. OASDI receipts reached a new high of 12 billion 22 million dollars, but rapidly rising expenditures rose to 13 billion 270 million dollars. According to news sources, the Treasury Department does not expect to get the system into the black next year.

It is recalled that despite increases in tax rates and in the tax base in recent years, the social security system lost money in 1957, 1958, and 1959. Critics of the social security approach to health care of the aged have pointed out repeatedly that the addition of a health care program with its unpredictable costs would jeopardize the entire social security structure.

# AMA Los Angeles Meeting . . .

## This 16th Clinical Session, November 25 - 28 Offers Excellent Features for Most Physicians

THE 1962 Clinical Meeting of the American Medical Association will be held November 25 - 28 at Los Angeles, where an attendance of 12,000 is anticipated, half of them physicians. General arrangements are under the direction of Wilbur Bailey, M. D., past-president of the Los Angeles County Medical Association and of the California Medical Society.

The four-day meeting will open at noon Sunday, November 25, and will conclude at 5:30 p. m. Wednesday, November 28. House of Delegates headquarters will be in the Biltmore Hotel.

### Ohio Delegation

Official delegates of the Ohio State Medical Association scheduled to represent Ohio in the AMA House of Delegates in Los Angeles are the following: Drs. George W. Petznick, Cleveland; George A. Woodhouse, Piqua; Edmond K. Yantes, Wilmington; John H. Budd, Cleveland; Richard L. Meiling, Columbus; Paul F. Orr, Perrysburg; Charles A. Sebastian, Cincinnati, and Edwin H. Artman, Chillicothe.

Ohio alternate delegates scheduled to attend the meeting are: Drs. H. T. Pease, Wadsworth; Robert S. Martin, Zanesville; T. L. Light, Dayton; Harry K. Hines, Cincinnati; P. John Robechek, Cleveland; Frederick P. Osgood, Toledo; J. Robert Hudson, Cincinnati; Philip B. Hardymon, Columbus; and R. E. Tschantz, Canton.

The Ohio delegation will be accompanied by Messrs. Hart F. Page and Charles W. Edgar, of the OSMA Headquarters staff.

### Advance Registration

Coupons for advance registration and for hotel reservations are appearing in current issues of *The Journal of the AMA.*

Scientific sessions, general registration and scientific and industrial exhibits will be in the Shrine Auditorium.

A Sunday afternoon scientific session is scheduled at 2 p. m. in lieu of the customary Thursday morning session held at past clinical meetings.

Serving with Dr. Bailey on the committee on arrangements are Lewis T. Bullock, M. D., and Edward H. Crane, Jr., M. D., co-chairmen of the committee on scientific program; Leonard M. Asher, M. D., chairman of the committee on television; and Allan K. Briney, M. D., Ian MacDonald, M. D., and Reuben Dalbec, secretary.

### Scientific Features

More than 100 papers will be presented on the scientific program and more than 200 industrial and scientific exhibits will be displayed at the Shrine Auditorium.

The program on viral hepatitis will present the most recent findings in studies of the only infectious disease which has shown an increase in the United States in recent years. Among those reading papers will be Joseph D. Boggs, M. D., of Northwestern University Medical School. Dr. Boggs gave a short paper in June, 1961, at the AMA's annual meeting in New York City, reporting on studies that indicated an approach to developing a hepatitis vaccine.

The aerospace medicine program will feature papers by several physicians who have a leading part in the astronaut program, and also will include presentations by medical directors of an air line and an aircraft manufacturer regarding medical problems encountered in commercial aviation.

Air pollution will be studied from various aspects, with special emphasis on air pollutants that may cause physical ailments that require medical treatment.

Two units of the program will deal entirely with cancer, one on the etiology and pathogenesis of cancer and the other on new developments in chemotherapy for cancer. In addition a number of papers on other aspects of cancer will be presented on several other segments of the program.

### Highlights

Highlights of the program are as follows:

Sunday afternoon — Air pollution and pulmonary disease.

Monday morning — Viral hepatitis; cineradiography; general surgery; clinical nuclear medicine.

Monday afternoon — New approaches to depression and suicide; anesthesiology; thoracic surgery; disturbances of growth in children.

Tuesday morning — Etiology and pathogenesis of cancer; forensic medicine in clinical practice; urology.

Tuesday afternoon — Chemotherapy of cancer; neurosurgical program; gynecological and obstetrical program.

Wednesday morning — Medical management of cardiovascular disease; symposium on dermatologic surgery; viruses.

Wednesday afternoon — Aerospace medicine; orthopedics; ear, nose and throat.

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# AMERICAN MEDICAL ASSOCIATION

## 16TH CLINICAL MEETING

### Los Angeles
### November 25-28

*America's fastest growing city plays host to the nation's biggest winter medical session—the AMA Clinical Meeting. For the first time in eleven years, the AMA will present in Los Angeles a complete, comprehensive four-day program featuring the newest advances in medicine.*

*Planned for every physician, the entire scientific program, scheduled in convenient Shrine Auditorium, offers the most up-to-date "refresher courses" and findings in recent research.*

SPECIAL PROGRAM HIGHLIGHTS
*SUNDAY THROUGH WEDNESDAY*

Air pollution and pulmonary disease
Viral hepatitis
Clinical nuclear medicine
Depression and suicide
Surgery—general, dermatologic, thoracic and neurologic
Cancer—etiology, pathogenesis, and chemotherapy
Orthopedics
Children's growth disturbances
Cineradiography
Anesthesiology
Forensic medicine
Aerospace medicine
Obstetrics and gynecology
Cardiovascular disease
Viruses
Otolaryngology
Rhinology

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See JAMA October 27 for complete scientific program, for physician registration and hotel reservation forms.

**WHEN WINTER COMES, "CATCH UP" AT THE AMA CLINICAL MEETING IN CALIFORNIA**

# Disaster Institute Planned . . .

## OSMA Committee Joins with Other Organizations In Sponsoring Two-Day Program December 1 and 2

"THE Advanced Institute for Mobilization of Health Services in Emergencies" will be the wrap-up of a year of high pitched activity for the Ohio State Medical Association's Committee on Disaster Medical Care. The general theme of the Institute, to be held on December 1 and 2, is indicated in its title. It is, simply, "how physicians and other organizations responsible for health care best mobilize their efforts and work jointly and effectively to meet the demands of major health emergencies, whether they be natural or nuclear."

Program begins at 1:00 p. m. Saturday, December 1, at the Ohio Youth Center, State Fair Grounds, Columbus.

The Institute will be jointly sponsored by the Ohio State Medical Association, The Ohio Hospital Association, Ohio Department of Health, Regional American Red Cross and Ohio Civil Defense. The program deals with the coordination and cooperation that is necessary among these organizations concerned with disaster relief in order that the most effective medical and hospital care is provided for mass casualties.

The Institute will provide the latest word on federal emergency planning from the Department of Health, Education and Welfare and from the Department of Defense. It will bring the participants up to date on the work of the disaster planning committees of the American Medical Association and the American Hospital Association.

### Operation Know-How '62

Operation Know-How '62, a simulated civil disaster involving 525 casualties was staged in Cleveland on October 13. This drill, the third of its type, was set-up to test transportation, communications and hospital management of mass casualties.

Following the drill, an evening program was held. At that meeting, umpires' reports of the effectiveness of program were given and reviewed by Dr. Carruth Wagner of the U. S. Public Health Service.

In conjunction with this drill, Dr. Wendell A. Butcher, chairman of the OSMA Committee on Disaster Medical Care, mailed invitations to all county medical society disaster committee chairmen, to all local executive secretaries, and to members of the state committee urging all to attend and participate in the Cleveland mock disaster.

### OSMA Disaster Conference

Earlier this year, on June 17, the committee sponsored a "Disaster Medical Care Conference" at the Ohio Exposition Grounds in Columbus. Some fifty Ohio physicians, largely county medical society disaster committee chairmen, attended the meeting, (see August, 1962 OSMA *Journal*, page 946 for complete details). This meeting was considered very successful and another such meeting is being planned by the committee for next year.

### Future Programs

The Committee is presently considering the establishment of a districting system for state disaster programs. This type of system would replace the present county system. The purpose of the switch is to aid in the coordination of disaster planning efforts of large metropolitan counties and their surrounding counties, in order that more effective overall plans are developed.

The Committee is also considering studies in the area of chemical and bacteriological warfare.

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## Akron Doctors' Orchestra Starts 37th Season

On September 13 the Doctors Orchestra of Akron, the oldest doctor orchestra in the world, held the first rehearsal of its 37th season. Organized by A. S. McCormick, M. D., in November, 1926, it has given 244 concerts for 33 hospitals, other institutions and organizations, including a concert in Columbus for the Ohio State Medical Association.

Eight concerts will be given during this season. It has given 9 benefit concerts for hospitals. R. P. Bragg is Director. Dr. McCormick, 86, retired as director in 1961 and is now Director Emeritus. He has directed 33 American and Canadian bands and orchestras and is believed to be the oldest orchestra director in the United States. He has also composed music for American, Canadian, British and Australian bands. Director Bragg formerly directed the 6th U. S. Army Band. Concertmaster is Arthur Dobkin, M. D.

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## New Law on Outpatient Treatment For Certain Veterans

A new law signed by the President on August 14 makes peacetime veterans with service-connected but non-compensable disabilities (less than 10 per cent) eligible for VA outpatient medical and dental treatment and for VA hospitalization.

The Veteran must secure approval from the nearest VA regional office before he goes to a private physician or dentist at VA expense.



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Investigators have found the antidiarrheal action of Lomotil not only "excellent"[2] but "efficacious[3] where other drugs have failed. . . ."

**DOSAGE:** For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

**NOTE:** Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.


1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21 674-680 (Sept.-Oct.) 1958.
2. Kosich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35 46-49 (Jan.) 1961.
3. Weingarten, B.; Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35 628-633 (June) 1961.


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*Research in the Service of Medicine*

# Do You Know?

George H. Saville, Director of Public Relations of the Ohio State Medical Association, participated in a panel discussion entitled "Community Health Services Development through the Legislative Process," October 2, at Columbus. The meeting was sponsored by health and hospital council executives of Columbus, Cincinnati and Cleveland in the hope of establishing a focus on local metropolitan community leadership and participation in the development of needed health legislation in the state legislature.

* * *

Dr. Ralph E. Dwork, Director of the Ohio Department of Health, was elected secretary-treasurer for a term of three years of the Association of State and Territorial Health Officers, at its meeting in Washington, D. C.

* * *

Stanley A. Ferguson, director of University Hospitals of Cleveland, was chosen president-elect of the American Heart Association at its recent meeting in Chicago. He will assume the presidency next year at the annual meeting in New York.

* * *

Dr. Frank C. Sutton, Dayton, was installed as president of the American College of Hospital Administrators at the meeting of hospital organizations in Chicago. In addition to many local and national posts, Dr. Sutton is past-president of the Ohio Hospital Association and chairman of OHA Professional Relations Committee.

* * *

Sidney Lewine, director of Mt. Sinai Hospital of Cleveland, was appointed by the American Hospital Board to its Council on Administrative Practices. Mr. Lewine is presently first vice-president of the Ohio Hospital Association Board of Trustees.

* * *

Dr. Robert M. Inglis, Columbus, OSMA Tenth District Councilor, has been elected chairman of a 15 member committee to follow up recommendations of a recent study on voluntary health agencies. The committee is composed of representatives of the Columbus Academy of Medicine, the United Community Council and United Appeal.

* * *

Former Akron Health Director Dr. George James has been named health commissioner of New York City.

* * *

Dr. Frederic N. Silverman, associate professor of radiology and pediatrics at the University of Cincinnati College of Medicine, recently spoke before the International Pediatric Congress in Lisbon, Portugal.

Assistant Surgeon General Arnold B. Kurlander, formerly of Cleveland, has retired from the U. S. Public Health Service to become director of Sinai Hospital in Baltimore.

* * *

Dr. Arthur E. Rappoport, director of laboratories for the Youngstown Hospital Association, has been elected to the board of governors of the College of American Pathologists.

## Provisions of New U. S. Drug Control Bill

**The new drug control bill enacted by the 87th Congress and signed by the President contains provisions which:**

**(a) require manufacturers to prove the effectiveness as well as safety of their products; (b) give the FDA broader authority to inspect the records and factories of drug manufacturers; (c) make illegal any drug advertisement which does not contain a summary of adverse side effects; (d) authorize the FDA to suspend swiftly any drug which it suspected was dangerous; (e) require physicians to obtain the consent of patients before giving them experimental drugs, unless the physician determines this would not be feasible or not in the best interest of the patient; (f) require certification, through batch-by-batch testing, of all antibiotics for human use; (g) require that new drugs be tested on animals before they are given to human beings in clinical investigations.**

Dr. Harriet Gillette of the Cleveland Clinic has been elected secretary of the American Academy of Physical Medicine and Rehabilitation at its 24th annual meeting in New York City.

* * *

Dr. Robert J. Atwell, native Chillicothean, has been chosen by the U. S. government to be one of 16 men who will conduct a patient population experiment on the food process services in Kuala Lumpur, Malaya.

* * *

At the recent XII International Congress of Dermatology, in Washington, D. C., a citation was presented to Dr. Hugo Hecht, Cleveland, in recognition of his lifelong service to medicine, and to commemorate his attendance at the VII International Congress of Dermatology held in Rome 50 years ago.

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*BLADDER SPASM*

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In Our Opinion

# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*
*— Justice Robert H. Jackson in AAA Supreme Court Case, 1942*

### IT'S TIME TO SEND THAT CHECK TO AMA - ERF

Have you made your contribution this year to the American Medical Association Education and Research Foundation? Have you donated to the Alumni Fund of your own medical school? If not, you still have time to join with the majority of your Ohio colleagues in making an investment in the continuation of our present system of medical education? The Foundation's address is: 535 N. Dearborn St., Chicago 10, Illinois.

### COPE'S CHARGES ARE REFUTED

Useful to Ohio physicians and others who may wish to answer irresponsible charges made by Cope, the AFL-CIO political machine against the AMA, during the recent election campaign, will be a new pamphlet produced by the AMA, entitled "The Health Care Issue." It not only rebuttals the statements made by Cope but carries much factual information about the basic issue of compulsory health insurance. Those who may want to set the record straight can get a copy from the AMA headquarters, 535 N. Dearborn Street, Chicago 10.

### MEDICARE FOR RETIRED WORKERS BY INDUSTRY SHOULD BE BOOSTED

All major U. S. companies should provide "industrial medicare" programs for retired employees, John T. Connor, president of Merck & Co., told the American Hospital Association Convention. Connor said that company-sponsored health insurance during retirement offers "exciting possibilities" of progress in the over-all problem of helping elderly persons meet medical costs.

Every unit of government which does not now do so should also "devise adequate plans for taking care of the health needs of its own retired employees," Connor suggested.

Connor's points are important. Industry should take a look at its retirement policies. Action now as Connor suggested may go far toward warding off government action under political pressure.

### YOUR SHARE IN THE TAX DOLLAR

Those who believe in efficient and adequate governmental services but not wasteful, extravagant and unnecessary governmental activities may want to tuck away the following figures for use in rebuttal:

At least 30 cents of every dollar you pay for gasoline is a direct state or federal tax.

33 cents of every grocery dollar is a direct or an indirect tax.

The average man works more than 2½ hours out of every 8 hour of workday, just to pay his taxes.

In a $10,000 house, there are 600 hidden taxes amounting to about $2,000.

### "SABIN ON SUNDAY" IS PUBLIC SERVICE AT ITS HIGHEST

How many thousands of man hours have Ohio physicians and their colleagues in the ancillary services given to the oral polio vaccine program this year, known in some areas as the "Sabin on Sunday" program? Or, to put the emphasis where it belongs, how many lives and limbs have been saved? This is public service in the true professional sense of the term.

Public response has been beyond all expectations, another indication that the people of Ohio have the utmost faith in their doctors. This is the reward doctors receive for their time and effort — satisfaction in knowing that it is a job well done and knowledge that the public accepts it as a public service.

Much has been written about the traditional family doctor of years gone by. The glory which was his is now being amplified by the public service activities engaged in by the modern physician, armed with the modern weapons for preventing and combatting disease.

### STUDENT LOAN FUND PROJECT IN NEED OF MORE MONEY

A far reaching new medical education loan guarantee program is now under way in American medicine. The goal of this program is to help eliminate the financial barrier to medicine for all who are qualified and accepted by approved training institu-

**in low back pain**



# Trancogesic helps the whole patient by breaking the triad of pain

The action of Trancogesic is direct and as simple as 1, 2, 3. Its tranquilaxant component—chlormezanone—1. reduces emotional reaction to pain...2. decreases skeletal muscle spasm...and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic treats the *whole* pain complex, helps the *whole* patient—*with unsurpassed safety.*

Each tablet of TRANCOGESIC contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily; the dosage suggested for children from 5 to 12 years is 1 tablet three or four times daily. Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects, and contraindications. WINTHROP LABORATORIES, NEW YORK 18, N. Y.

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tions. It is designed to provide a means of financing a substantial portion of the cost of a medical education.

The loan program for medical students, interns and residents is the result of a cooperative effort by American medicine and private enterprise.

The program is administered by the American Medical Association's Education and Research Foundation. The ERF has established a loan guarantee fund. On the basis of this fund, the bank will lend up to $1,500 each year to students. The ERF in effect acts as cosigner. For each $1 on deposit in the ERF's loan guarantee fund, the bank will lend $12.50.

More than 3,300 students, interns and residents have borrowed more than $6,000,000 through this fund since it was started last February. Physicians and others have contributed almost $700,000 to the loan guarantee fund, which makes possible these loans.

Through August 20, 1962, 50 loans had been made to Ohio applicants. The amount loaned for those in medical school totaled $52,100 and to those in hospital training, $67,300.

The guarantee fund is almost depleted and more money is needed immediately to keep up the loan program. Eventually it will become self-sustaining as loans are repaid, but right now substantial financial help is needed. Your check to the AMA-ERF, 535 North Dearborn St., Chicago, will help to keep this important program viable. Contributions to the Foundation are tax deductible.

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### VALUE OF THE ITEMIZED STATEMENT

"An itemized bill best way to explain medical charges" states a headline in the AMA News. Amen say those who have been trying for years to get physicians to realize just that.

If a physician should get a bill from his garage marked "for work performed" he probably would blow his top. What about the patient who gets a bill "for professional services" when several kinds of professional services may have been rendered and the patient hasn't the slightest idea what they were for or how much each was worth?

Explaining the bill, orally or in writing, is a patient relations must for the doctor.

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### THAT PERIODIC PHYSICAL EXAM — FOR YOU, DOCTOR

More than 1700 physicians who attended the Chicago AMA Session last June availed themselves of the clinical pathology tests made at the meeting as a professional service. Compilation of results showed that more than two-thirds of the physicians who underwent the series had "significant abnormalities." Such a demonstration should act as a constant reminder to all physicians: Get that periodic check-up yourself. It may save you grief later, and perhaps add many years of useful service in the profession.

### CHECK LIST ON COMMUNITY HEALTH SERVICES

Pamphlet No. 180-5 of the Public Affairs Committee, Inc., 22 E. 38th Street, New York 16, is entitled "Community Health Services; The Case of the Missing Mileposts." It's good. Get a copy for 25 cents.

Of special interest in the publication is a health service check list. The list is intended for citizens, to alert them on the situation which exists in their community.

This list is an excellent blueprint for County Medical Society research and action on community health problems. Here's the list for use in your county:

- What is your community doing to protect you from polluted air? Is it doing enough?
- Does your community provide you with a safe supply of fresh water? Will it last?
- What is done to prevent contamination of fresh milk, fruit, meat, and vegetables? What is done to protect you against contamination of canned and packaged foods, drugs, household chemicals?
- Are beaches, ponds, lakes, streams, and pools protected from pollution?
- Are sewage, garbage, and trash properly taken care of?
- What facilities or activities are there to protect you against person-to-person infections? What is the danger?
- Does your community provide special health care for infants, young children, and their mothers?
- Is health care available to all aging and dependent persons, to the chronically ill? Is restorative care readily available to the disabled?
- What do your schools do for child health?
- Does your community provide visiting nurse service?
- Are the health services in your community adequate to meet the needs of the people at present? Do they represent effective application of currently available knowledge and technology?
- Is there a community health plan, looking ahead to adequate service 10 years from now? 20 years from now? At century's end?
- Does the health plan assess the resources of the community (skills, funds, facilities, favorable conditions) in order to make them productively useful now and in the future?
- How much does community health service cost? How much of the bill do you pay? How do you pay it? Do you think you are getting your money's worth?
- What health services are provided in your community by agencies to which you contribute funds in response to special fund-raising appeals?
- Is there a central referral center in your community for persons seeking information about needed health services?
- Do you have anything to say about your community's health services? To whom do you say it? How?

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Obituaries

# Ad Astra

Edgar Paul Adams, M. D., West Palm Beach, Fla. (formerly of Warren); University of Maryland School of Medicine and College of Physicians & Surgeons, 1919; aged 67; died August 8; former member of the Ohio State Medical Association. Dr. Adams was superintendent of the Trumbull County Tuberculosis Hospital from its opening in 1928 until 1952. He retired in the latter year and moved to Florida. A member of the Methodist Church, he is survived by his widow.

Nathan Worth Brown, M. D., Sylvania; Western Reserve University School of Medicine, 1903; aged 84; died September 25; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. Dr. Brown was living in retirement after a long and active career in the Toledo area where he pioneered in cardiology. He was active also in a number of organizations; was a member of the Baptist Church, the Masonic Lodge, Sons of the American Revolution, Torch Club, Ancestral and Historical Association, and other groups. He was a veteran of the Spanish-American War and served in the Medical Corps during World War I. Dr. Winship H. Brown of Maumee is a son. Also surviving are a daughter and another son in Florida.

Charles Alfred Craig, M. D., Cambridge; Starling Medical College, Columbus, 1906; aged 83; died September 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Craig was a practicing physician in Cambridge from 1919 until his retirement in 1957. Previously he practiced for a time in Ava and at Senecaville. From 1942 to 1948 he was in the Ohio House of Representatives. Affiliations included membership in the Masonic Lodge and the Kiwanis Club. Surviving are his widow, two sons and a brother.

Charles C. Crosby, M. D., Ashtabula; University of Pennsylvania School of Medicine, 1902; aged 85; died September 24; former member of the Ohio State Medical Association. Dr. Crosby's career extended over some 54 years in Ashtabula where he specialized in the field of eye, ear, nose and throat practice. From 1940 to 1947 he was Ashtabula County health commissioner. A veteran of World War I, he was a member of the American Legion and Veterans of Foreign Wars. Other affiliations included memberships in the Elks Lodge, the Rotary Club and the Episcopal Church. Surviving are four sons and stepsons.

Charles Wesley Evans, M. D., Springfield; Starling Medical College, Columbus, 1898; aged 91; died September 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Evans opened his practice in Springfield on completion of his medical training and continued in practice until recent months in spite of his advancing years. He was active in civic and educational work; served on the Springfield Board of Education for many years as member and president. Whittenberg University conferred its Community Leadership Award on him. A member of the Methodist Church, he is survived by his widow and a son.

Charles E. Howard, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1908; aged 77; died September 25; member of the Ohio State Medical Association, the American Medical Association, American Proctologic Society; Fellow of the American College of Surgeons; diplomate of the American Board of Colon & Rectal Surgery. A native of Cincinnati, Dr. Howard served all of his professional career there. A specialist in proctology, he was former vice-president of the American Proctologic Society and a charter member of the local Proctologic Society. Affiliations included membership in the Masonic Lodge and the Ohio Society Sons of the American Revolution. Survivors include his widow, a son and two daughters.

Nathaniel Moore Jones, M.D., Cleveland; Western Reserve University School of Medicine, 1902; aged 84; died September 20; former member of the Ohio State Medical Association; Fellow of the American College of Surgeons. A native of Cleveland, Dr. Jones served most of his professional career there, taking time out for study abroad and for service during World War I. For a number of years he was surgeon for the city of Cleveland. Surviving are his widow and a stepson.

Francis Edgar Mahla, M. D., Toledo; Ohio State University College of Medicine, 1913; aged 76; died September 31; member of the Ohio State Medical Association and the American Medical Association. Dr. Mahla began practice in Marion and remained there until 1935 when he was appointed assistant director of the Ohio Department of Health. From 1940 to 1949 he was Erie County health commissioner and in the latter year was named Lucas County health commissioner, a post he held until 1959. A veteran of World War I, he was a member of the Presby-

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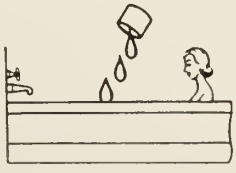
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1. Borota, A., and Grinell, R. N.: J. Amer. Geriatrics Soc., 10:413, 1962. 2. Spoor, H. J.: N. Y. State J. M., 58:3292, 1958. 3. Lubowe, I. I.: Western Med., 1:45, 1960. 4. Weissberg, G.: Clin. Med., 7:1161, 1960. 5. Lieberman, W.: Amer. J. Proctology, 12:374, 1961.

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terian Church and the Masonic Lodge. Surviving are his widow and two sons.

**William Byrne Morrison**, M. D., Columbus; Jefferson Medical College of Philadelphia, 1922; aged 67; died September 25; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A native of West Virginia, Dr. Morrison took his internship and residency training in Columbus, later going into surgical practice there. He was active in local affairs, was a past-president of the Academy of Medicine of Columbus and held memberships in a number of organizations; was also a member of the Episcopal Church and several Masonic bodies. A veteran of World War I, he later attained the rank of major in the Medical Reserve Corps. Survivors include his widow and two daughters.

**Harry Allen Neiswander**, M. D., Pandora; Cleveland-Pulte Medical College, 1912; aged 80; died September 4; member of the Ohio State Medical Association and the American Medical Association. Dr. Neiswander served all of his professional career in and around the Putnam County community of Pandora, recently completing 50 years in practice. For 15 years he was county health commissioner and served many years on the board of education. Affiliations included memberships in the Methodist Church and the Kiwanis Club. Surviving are his widow, two sons, one of whom is Dr. Allen Neiswander, of Alhambra, Calif., and a daughter; also two sisters and three brothers, including Dr. Byron Neiswander, of Doylestown.

**Alfred Curtis Ormond**, M. D., Zanesville; Harvard Medical School, 1927; aged 62; died September 21; member of the Ohio State Medical Association and member of the OSMA Judicial and Professional Relations Committee; member of the American Medical Association; Fellow of the American College of Surgeons and the International College of Surgeons. Dr. Ormond began his practice in Byesville in Guernsey County, after residency training in the East. He moved to Zanesville in 1934. Active in hospital and community affairs, he was a member of the Rotary Club and the Presbyterian Church. During World War II, he served overseas with the Medical Corps and attained the rank of lieutenant colonel. Surviving are his widow, two sons and a brother, Dr. Alexander P. Ormond, of Akron.

**Irving Lawrence Schonberg**, M. D., Shaker Heights; Ohio State University College of Medicine, 1931; aged 55; died September 13; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Dermatology and Syphilology; diplomate of the American Board of Dermatology. A native of the Cleveland area, Dr. Schonberg served all of his professional career there with the exception of time served in the Medical Corps during World War II. A member of the Temple, he is survived by his widow, a son, a daughter, his mother and a brother, Dr. Albert Schonberg, of Albuquerque, New Mexico.

**Louis Ernest Valker**, M. D., Hamilton; Creighton University School of Medicine, 1925; aged 61; died September 18; member of the Ohio State Medical Association, American Medical Association and the American Academy of Dermatology and Syphilology. Dr. Valker practiced for some 25 years in Hamilton, specializing in dermatology. He was a member of the Catholic Church. A son, Dr. Louis E. Valker, Jr., is a Hamilton physician and was associated with his father in practice. Also surviving are his widow, another son, and a daughter.

## Cincinnati Area GP's

The Southwestern Ohio Society of General Physicians in collaboration with the University of Cincinnati College of Medicine presented a seminar entitled "Chest Disease" for General Physicians at the Academy of Medicine Office on October 21.

This is one of a series of programs presented by the SOSGP for physicians in the Cincinnati area.



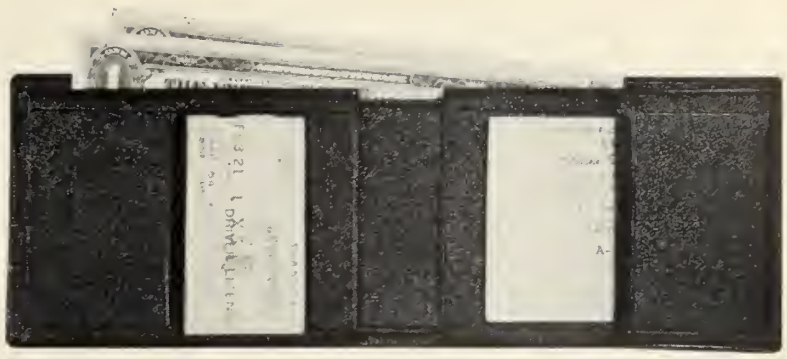

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# Buckeye News Notes . . .

**Cincinnati**—Dr. Frank H. Mayfield, past-president of the Ohio State Medical Association, participated in a panel discussion on "Cervical Spine and Pain" at the Clinical Congress of the American College of Surgeons in Atlantic City. Dr. Mayfield is the Chairman of the American Board of Neurological Surgery.

**Cincinnati** — Dr. Kenneth MacLeod, Cincinnati health commissioner, discussed "The Role of the Health Department in Community Health Planning" at a recent meeting of District Eight, Ohio State Nurses Association.

**Cincinnati**—Dr. William A. Altemeier of the University of Cincinnati Medical Center was the sole United States representative at a recent London meeting on worldwide problems in hospital infection. Dr. Altemeier was selected to represent the U. S. by the National Academy of Sciences and the National Research Council.

**Cleveland**—Greater Cleveland's first Health Careers Fair was sponsored by the Cleveland Hospital Council and the Academy of Medicine of Cleveland in early October. Booths were set up to present information on about 12 vocations: medicine, dentistry, occupational therapy, social service, nursing, dietetics, podiatry, medical records service, physical therapy, pharmacy and x-ray technology.

**Columbus**—Dr. Donald S. O'Leary, Columbus, discussed the King-Anderson bill and socialized medicine at a recent meeting of the Sertoma Club held at the Pick Fort Hayes Hotel.

**Gallipolis**—Dr. J. A. DeLamerens has taken up his duties as the Holzer Hospital pathologist and director of laboratories. He is a member of the Holzer Clinic staff and replaces Dr. Gerald Obert, who is now teaching at the University of North Dakota. Dr. DeLamerens came to Gallipolis from Suffolk, Virginia.

**Killbuck**—Dr. Paul Roth was the guest speaker at a recent meeting of the Killbuck Lions Club. Dr. Roth presented a talk and illustrative slides about his work as a mission doctor while in Puerto Rico.

**Marion**—Dr. F. T. Merchant was the guest speaker for the first meeting of the season of the Marion District of the Ohio State Nurses Association. Dr. Merchant's topic was "Post Operative Care of the Surgical Patient."

**Newark**——Dr. D. R. Sperry was chosen "Boss of the Year" at a recent meeting of the Licking County Association of Medical Assistants.


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**Handbook for Medical Societies and Individual Physicians on National Voluntary Health Agencies:** This book, issued by the American Medical Association's Committee on Voluntary Health Agencies, gives information which will serve as a guide in relationships between medicine and allied health agencies. Listed for each national voluntary agency are its major purpose, organizational structure, financing and fund raising program and key personnel. Medical societies and physicians can order copies of the revised *Handbook* by writing their request on their professional letterhead to AMA Committee on Voluntary Health Agencies, 535 N. Dearborn, Chicago 10, Illinois. There is no charge for original orders under 50 copies. A charge of $1 per copy is made for orders of more than 50 copies.

* * *

**Reviews of Medical Motion Pictures.** This annual publication is now available on request from the Film Library of the A. M. A. It is prepared by the Division of Communications, Department of Medical Motion Pictures and Television and contains reprints of all reviews published in the JAMA during 1961.

# Coming Meetings . . .

**Ohio State Medical Association,** 1963 Annual Meeting, Cleveland, May 12-17.

**American Medical Association,** Clinical Meeting, Los Angeles, Calif., November 25-28.

**Academy of Medicine of Cleveland and Cleveland Bar Association** joint meeting to hear Dr. Edward R. Annis, December 10.

**Academy of Medicine of Columbus and Franklin County,** Clinic Day Type Program, Columbus, November 19.

**Advanced Institute for Mobilization of Health Services in Emergencies,** Ohio Youth Center Building, Columbus.

**American Society of Hematology,** Annual Meeting, Columbus, November 26.

**American Laryngological and Otological Society,** Middle Section Meeting, Cleveland, January 13-14.

**Cleveland Clinic Education Foundation,** Newer Developments in Ophthalmology, December 5-6.


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# Activities of County Societies...

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### HAMILTON

Dr. Carl W. Koehler was installed as president of the Cincinnati Academy of Medicine at its annual meeting recently. Dr. Joseph E. Ghory was installed as president-elect. Other officers are Dr. Joseph G. Crotty, secretary; Dr. Calvin F. Warner, treasurer; Dr. J. Harold Kotte and Dr. Daniel V. Jones, trustees; and Dr. Virgil A. Plessinger, councilman-at-large.

Featured speaker at the meeting was Clarence Manion, South Bend, Indiana, lawyer and former law dean at Notre Dame University, who spoke on the subject of socialism.

## Second District

(COUNCILOR: GEORGE J. SCHROER, M. D., SIDNEY)

### MONTGOMERY

Dr. Richard H. Overholt of Boston was the guest speaker at the October meeting of the Montgomery County Medical Society. Dr. Overholt is clinical professor of surgery at Tuft's University School of Medicine and director of the Overholt Thoracic Clinic in Boston.

Dr. Overholt reported on recent work toward development of surgery as satisfactory treatment of bronchial asthma and recent observations concerning surgery and cancer of the lung.

## Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

### ALLEN

Dr. Jay L. Ankeney, associate professor of cardiovascular surgery at Western Reserve University's School of Medicine, was the featured speaker at the first fall meeting of the Allen County Academy of Medicine. Dr. Ankeney discussed "The Present Status of Cardiac Surgery." His talk also included a discussion of congenital heart disease and acquired valvular disease such as the type seen in rheumatic fever.

## Fifth District

(COUNCILOR: HENRY A. CRAWFORD, M. D., CLEVELAND)

### CUYAHOGA

The November meeting of the Academy of Medicine of Cleveland and Cuyahoga County will be cosponsored by the Cancer, Surgical, General Practice and Obstetric-Gynecology Societies. The meeting is scheduled for November 7.

## Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

### COLUMBIANA

Cornell Monda, Lisbon school psychologist, was the featured speaker at a recent meeting of the Columbiana County Medical Society. He discussed psychological counseling at the East Liverpool Child Counseling Center.

### MAHONING

A free buffet dinner was the highlight of the first meeting of the fall for the Mahoning County Medical Society. Following the dinner, a business meeting was held.

### SUMMIT

A panel discussion concerning "The Geriatric Problem" was the feature of a recent meeting of the Summit County Medical Society. Participating in the panel were Dr. J. T. Villani, Mr. Don Van Valen,


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Dr. J. D. Morley, Mr. C. V. Kibler and Dr. B. L. Boynton. The panel discussion was followed by a regular business meeting.

### TRUMBULL

The first meeting of the fall season of the Trumbull County Medical Society and the Medical Auxiliary was a joint dinner-meeting held at the El Rio. Dr. Thomas E. Wilson, president and co-chairmen Dr. E. R. Westbrook and Dr. C. W. Muter gave a detailed report on the Sabin Oral Sunday project.

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D. MARTINS FERRY)

### BELMONT

Dr. Emmerich von Haam, chairman of the department of pathology, Ohio State University College of Medicine, discussed "Death of Medico-Legal Importance" before a joint meeting of the Belmont County Medical Society and the Belmont County Bar Association in late October.

## Ninth District

(COUNCILOR: CHESTER H. ALLEN, M. D., PORTSMOUTH)

### LAWRENCE

Dr. R. Dean Dooley, director of professional relations of Ohio Medical Indemnity, Inc., presented a "Review of O. M. I. in Lawrence County" before a quarterly meeting of the Lawrence County Medical Society held recently at the Patio restaurant.

### SCIOTO

A panel discussion concerning "Relationship Between the Doctor, the Clergy and the Patient" was presented at the October meeting of the Scioto County Medical Society. The moderator was Dr. Jerome Sheets and participating on the panel were Father Dunn, Reverend Clyde Pinnell, Dr. Sol Asch and Dr. William Scaggs.

## Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

### FRANKLIN

Dr. Edward R. Annis, president-elect of the American Medical Association, was the speaker at a recent dinner meeting of the Academy of Medicine of Columbus and Franklin County held at the Deshler-Hilton Hotel. Dr. Annis spoke on the physician's changing role in legislative activities.

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

One hundred and fifty-two persons attended the September meeting of Lorain County Medical Society, where physicians and their wives enjoyed the recreation and inspiration provided by "Ohio's Ambassador


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of Goodwill" — Dr. Tennyson Guyer of Findlay, who spoke on "The Life of Your Time."

A social hour and dinner at Oberlin Inn preceded the meeting. Dr. R. E. Hayes presided and welcomed four new physicians and their wives.

Dr. Harold A. Robinson gave the Memorial Address for George D. Nicholas, M. D., a physician in the Elyria area for over 50 years.

Dr. John W. Wherry announced the response of the membership to the poll on two-third regular fees for those over 65 with annual incomes of less than $4,000, as suggested in connection with the forthcoming Blue Shield-Blue Cross open enrollment. The Society went on record as accepting this.

Dr. J. A. Cicerrella, as chairman of the Oral Polio Immunization Program, announced the progress of plans, and urged the full co-operation of members on the three scheduled Sundays.

Dr. L. C. Meredith, Eleventh District Councilor, spoke briefly and reminded members of the coming District Meeting at Ashland Country Club, planned to honor O. S. M. A. president-elect H. T. Pease, former Councilor for this district.

Drs. William L. Hassler and Jose M. Sandigo were elected to active membership in the Society and Dr. William S. Skaryd to associate membership.

### RICHLAND

The September meeting of the Richland County Medical Society was held in the dining room of the Mansfield General Hospital. Following dinner, the business meeting was called to order by the president, Dr. Karl Kuehne.

Dr. Frederick Marshall, local dentist, spoke briefly in favor of the renewal of the Richland County Welfare Levy in the coming election. Dr. Harry Wain made the motion that the Society give its endorsement to the renewal of this levy.

Dr. Frank Wadsworth made the motion that the Society give its endorsement to the renewal of the Richland Tuberculosis Sanatorium levy. Both endorsements were passed unanimously by the Society.

Dr. Harry Wain, Richland County Health Commissioner, gave a report on the recent successful Sabin Oral Polio Vaccine Sundays, during which approximately 75,000 Richland County inhabitants were immunized against all three types of polio virus.

Dr. Ernest Mainzer made the motion that any further immunizations with the Oral Vaccine be carried out in the offices of the local physicians. This was approved by the Society.

Dr. Donald Dewald, Legislative chairman for the Society, gave a brief report on the political views of the state and local candidates for the coming election.

Dr. Carl Quick, Program chairman, introduced the speaker of the evening, Dr. G. Gwinup, who spoke on the subject of "Management of Arterial Sclerosis with Emphasis on Lipid Metabolism." Dr. Gwinup stated that the problem of Atherosclerosis in the United States has reached epidemic proportions, with one male out of every six likely to die of coronary artery disease before the age of 50. He further said that we know very little positive about the disease, and present concepts change from one month to the next.

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The Institute said other states with more than two-thirds of population covered by health insurance are California, Colorado, Delaware, Indiana, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Oklahoma, Oregon, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.

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# Activities of Woman's Auxiliary . . .

CHAIRMAN, PUBLICITY COMMITTEE—Mrs. Rivington Fisher, 549 Eastmoor Blvd., Columbus 9, Ohio
(Roster of Officers, Page 1321)

## ALLEN

The Sisters of Mercy entertained the Woman's Auxiliary to the Lima and Allen County Academy of Medicine Tuesday afternoon at the St. Rita's School of Nursing. The luncheon marked the second year the Sisters honored the Auxiliary for its initial meeting of the season. New members and wives of local interns and residents were honored guests.

The speakers, Dr. Carl Zinsmeister, legislative chairman for the Academy of Medicine, was introduced by the program chairman, Mrs. Thomas Leech. He gave an informative breakdown of the organization and activities of the Legislative Committee of the Ohio State Medical Association. He stressed the importance of each Auxiliary member's participation in the field of politics, by one's interest in the candidates and issues of the election, contributions to the party of one's choice, and actual voting and running for office where possible.

Mrs. R. L. Wiessinger, Auxiliary president, presided. She urged the members to be active, in this way supporting their Auxiliary, their husbands, and the American Medical Association. Mrs. J. M. McBride, Legislative Committee Chairman, reported that her committee will be busy by sponsoring "Coffee," transportation and babysitting on the day of election and the distribution of literature.

Mrs. K. F. Ritter, Historian, then announced the national award for the largest contribution to the American Medical Education Fund for Auxiliaries this size had been presented to the local Auxiliary for the third successive year. This is a true distinction since only six awards are given nationally.

The honored guests were new members, Mrs. Clyde Conger, Mrs. Kalman Pajor, Mrs. F. D. Rohdes, Mrs. R. E. Bushong, and wives of interns and residents, Mrs. Charles Stienecker, Mrs. Leopold Like, Mrs. Robert Busse.

The committee for the luncheon was headed by Mrs. Kinsbery, aided by Mrs. Connaughton, Mrs. Holladay, Mrs. Beery, Mrs. Oppenheim and Mrs. Shankland.

## CUYAHOGA

Medical Health Careers Chairman, Mrs. Arthur L. Watkins, presented a cash scholarship award to Miss Elaine Ebbert, Lakewood, in behalf of the Cleveland Academy Auxiliary. Miss Ebbert is a 1961 graduate of Lakewood High School and a sophomore in Medical Technology at Ohio University.

October 11 Cleveland Academy Auxiliary plays host to the Fifth District yearly luncheon meeting at the Academy of Medicine. Meeting started with workshop devoted to legislation. Mrs. Lee Ann Elliott, assistant director of AMPAC, spoke on "The Job Between Now and November 6th." Entertainment consisted of a presentation of "Skit Hits" from some of the successful skits presented in the past by Cuyahoga County.

Seven old records "cut" in 1939 and recently "discovered" awakened memories of the Symphonic Jazz Orchestra of the Cleveland Academy of Medicine dormant since 1940. The orchestra is being reactivated and is scheduled to give a symphonic jazz concert at the 16th Annual Chrysanthemum Ball of the Cleveland Academy of Medicine at the Rainbow Room—Carter Hotel Saturday, November 3. Proceeds go to the AMA - ERF fund.

Mrs. John Budd and Mrs. Edward F. Kieger, chairman and co-chairman respectively of the Chrysanthemum Ball, arranged to have the orchestra. Dr. J. L. Reycraft is again the conductor and Dr. Jerome Gross violin soloist. Dance music is in charge of Vincent Patti.

Cleveland Auxiliary started a Gavel Club for past-presidents of the Auxiliary. The first meeting was a luncheon at the Artists' and Writers' Club. Mrs. J. Kenneth Patten is chairman of the group.

Wives of doctors from other countries have been invited to an International Treasure Tea at the Academy building on November 16. They are being asked to come in costume and exhibit native treasures. Emphasis will be on the Thanksgiving season with a taste of old-fashioned holiday.

## FAIRFIELD

The first fall meeting of the Fairfield County Medical Auxiliary was held September 11 at the Lancaster Country Club. Mrs. Richard Welsh, presiding over the business meeting, pointed out that community service projects will be of great importance this year.

Mrs. F. E. Spangler announced that the group will again as in the past, manage and donate time to Red Cross Blood Bank.

This year, as last, the Auxiliary will share in support of the Cerebral Palsy Center, by holding monthly parties at the Center for teenage youngsters who would otherwise have little opoprtunity to associate with children their own age. Money will also be contributed to the Center from time to time for worthwhile causes.

Mrs. William Jasper thanked the group for donating funds for uniforms to the "Future Nurses" who

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gave of their time and efforts as "Candy Stripers" at the local hospital this past summer.

Plans for a Christmas card to represent the group were presented by Mrs. J. L. Kraker. All profit gained from this project will be given to the American Medical Association Educational Research Fund.

It was also agreed that the group will aid their husbands in the mass Sabin polio inoculation which began September 30. Mrs. G. F. Jones is in charge of this duty.

The business meeting was preceded by a festive fall luncheon planned by Mrs. James Merk, Mrs. F. W. James, Mrs. Spangler, and Mrs. Gordon B. Snider. The flowers and tables were arranged artfully with touches of autumn amber.

Handsome printed programs were issued to the group by Mrs. A. C. Essman, and the meeting was adjourned on a note of pleasant anticipation for a year of interesting and worthwhile projects.—*Lancaster Eagle Gazette.*

### FRANKLIN

The Woman's Auxiliary to the Academy of Medicine of Columbus and Franklin County are playing a vital part in the Sabin Oral Polio Vaccine Immunization Program for the population of Columbus and Franklin County. Auxiliary members are assisting the Academy of Medicine of Columbus and Franklin County in their goal of complete immunity for the population of this area.

September 30 Auxiliary members assisted at "Sabin Stations" with records, registrations, directing the flow of traffic both inside and outside these Stations, as cashiers, as contacts with school principals prior to the start of the program, and assisting in many ways in this most vital and worthwhile program. They are ready to repeat this on November 4 and January 6.

Our American Medical Association Education and Research Foundation Committee have been selling Christmas greeting cards with all profits to be turned over to the Foundation. This is their major project at present, to be followed by various others after the first of the year.

### SCIOTO

*The Portsmouth Times* gave an entire page in the social section for publicity on the "Tour of Homes."

A tour of several beautiful homes in and near Portsmouth was sponsored in mid June by the Woman's Auxiliary to Scioto County Medical Society.

The doctor's wives planned the tour as a ways and means project to support the auxiliary's various charities, which include the Fresh Air Camp, the Scioto County Home, a nursing scholarship, the Woman's Auxiliary of Portsmouth General Hospital, Mercy Hospital Guild, the Happy Hearts School, The American Medical Education Foundation and the Senior Citizens Club.

* * *

A salad smorgasbord luncheon at Madonna Hall of Mercy Hospital highlighted the first fall meeting of the Woman's Auxiliary to Scioto County Medical Society.

Following the luncheon, Rev. Robert L. Gushwa, a member of the citizens' committee speakers' bureau for the proposed Scioto County Community Hospital, gave a report on the bond issue for the proposed hospital.

Guest speaker for the afternoon affair was N. Dale Cox, who talked on his trip to Russia and showed colored slides.

Dr. Ruth B. Bennett, Dr. Marie B. Rogowski, Mrs. C. H. Chase and Mrs. Vincent Pentiuk were guests for the meeting.

Mrs. Jack MacDonald, auxiliary president, conducted a short business meeting.

The hostess committee included Mrs. J. P. McAfee, Mrs. A. L. Berndt, Mrs. Chester H. Allen, Mrs. William E. Daehler, Mrs. Harlan Williams and Mrs. Armin Melior, members of the auxiliary ways and means committee.

### TRUMBULL

Trumbull County Medical Auxiliary members are staffing the 31 stations throughout Trumbull County during the Sabin Oral Sundays to oversee administrative duties.

The volunteer program at Halsey Taylor Crippled Children's Rehabilitation Center will be continued during 1962-63.


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Vaginal Approach to Pelvic Surgery, One Week, Dec. 17
Gynecology, Office & Operative, Two Weeks, April 1, 1963
Obstetrics, General & Surgical, Two Weeks, Nov. 26, March 11, 1963
Proctoscopy & Sigmoidoscopy, One Week, Dec. 17, Jan. 28, 1963
Varicose Veins, One Week, Dec. 17, Jan. 28, 1963
General Surgery, One Week, February 25, 1963
Advances in Surgery, One Week, December 10
Board of Surgery Review, Part II, Two Weeks, Nov. 26, Mar. 4, 1963
Basic Internal Medicine, Two Weeks, March 4, 1963
Management of Common Fractures & Dislocations, One Week, Dec. 3
Board of Internal Medicine Review, Part II, One Week, Dec. 3
Breast & Thyroid Surgery, One Week, December 3
Gallbladder Surgery, Three Days, March 11, 1963
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# Important Change in OMI Claim Forms Discussed

By R. DEAN DOOLEY, M.D.
Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

OHIO physicians will observe in the near future a change in the Ohio Medical Indemnity claim form. The most drastic change is in the matter of space for the notation for physicians' charges. This is a departure from the thinking of the founders of Ohio Medical Indemnity. Being an indemnity insurance company, in which fixed benefit payments are made for stated specific procedures, physicians' charges are unnecessary in the processing of claims. Another very important reason for excluding consideration of physicians' charges is the original architects of Ohio Medical Indemnity, influenced by medical opinion current in 1945, proposed to steer clear of anything which might bear the remotest connotation of a third party in physician-patient relationships.

A new situation arose in 1959. Ohio Medical Indemnity was directed by the Ohio State Medical Association to develop an insurance program tailored to the needs of our elder population. At the same time, physicians were encouraged to adjust fees to the economic status of their elder patients.

It was decided that the program must have a reasonable level of benefit payments if it could expect to serve its projected purpose. Accordingly, the preferred level of fees was written into the contract and it was conjectured that, with such a fee schedule and with a possibility of reduced charges by physicians, overpayment would likely be a frequent occurrence.

To prevent such a contingency, a clause was written into the contract which states that the benefits paid to subscribers for professional services shall not exceed the actual charges submitted by attending physicians. This clause was not enforced the first ten months the program was in operation. However, after receiving many complaints from physicians and subscribers alike because of overpayment, this provision was enforced.

## "Not for Profit"

We found to the everlasting credit of Ohio physicians that the vast majority of them were making charges to our elder subscribers considerably below the going rate. Actually, the amount of overpayment without enforcement of the clause was substantial. There surely can be little disagreement with the thesis that insurance companies are not operated to produce profit for subscribers. By the same token, it is grossly unfair to physicians who reduce charges only to find their magnanimity has produced a sizable profit for their patients. Many subscribers complained that overpayment would inevitably result in higher premiums with resulting greater expense to them.

It is obvious that, as we move into the future and develop contracts with improved indemnity schedules, the problem of overpayment will be increasingly important. All new contracts contain the clause which requires a statement of physicians' charges, and I am very sure all future ones will likewise impose a similar requirement.

In order to enforce this provision, it is necessary for us to write our subscribers for a statement of their physicians' charges. This results usually in the subscribers requesting physicians to forward statements between billing periods to the annoyance of the physicians and consequent negative contribution to their pleasure and satisfaction of practice.

## New Claim Form

Many physicians have suggested to us that we develop a claim form which contains a space for the statement of physicians' charges. This idea has been presented to us so frequently that it has been implemented and will soon be contributing to the convenience of our physicians.

Daily we receive letters from physicians asking us to explain which contracts require a statement of charges and how they can be identified.

Contracts requiring a statement of charges are as follows: (1) The Special Preferred Contract, which is the one held by our elder citizens and was purchased in 1960; (2) The new Senior Preferred Contract was offered in the Spring of 1962; (3) The Major Contract, which is comparatively new in many areas of the state; (4) The Direct-Pay Special Preferred Contract is the one held by subscribers who retire from groups but continue to carry their insurance on a direct-pay basis. (5) The over-the-

counter Non-Group Preferred is sold in some Blue Cross areas; (6) The Select Contract is a special contract which was designed for subscribers in the Cleveland trading area. Statements are not required on the Standard or Preferred Contract. Inasmuch as the subscriber's identification card does not identify the contract, the best procedure is to indicate charges on all the claim forms and thereby eliminate the need of troublesome correspondence.

# New Members . . .

The following are the names of new members of The Ohio State Medical Association since September 1, 1962. The list shows the county in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

**Allen**

Fred D. Rohdes, Lima

**Defiance**

Robert R. Southworth, Defiance

**Hamilton**

Owen Lester Brown, Cincinnati
Eugene B. Elam, Cincinnati
Paul Joseph Haas, Covington, Kentucky
Sidney I. Lerner, Cincinnati
Robert M. Reece, Cincinnati
Nicholas J. Tapay, Cincinnati
Thomas U. Todd, Cincinnati

**Lucas**

Arturo Castillo, Toledo

**Mahoning**

Henry P. Bauer, Jr., Youngstown

**Montgomery**

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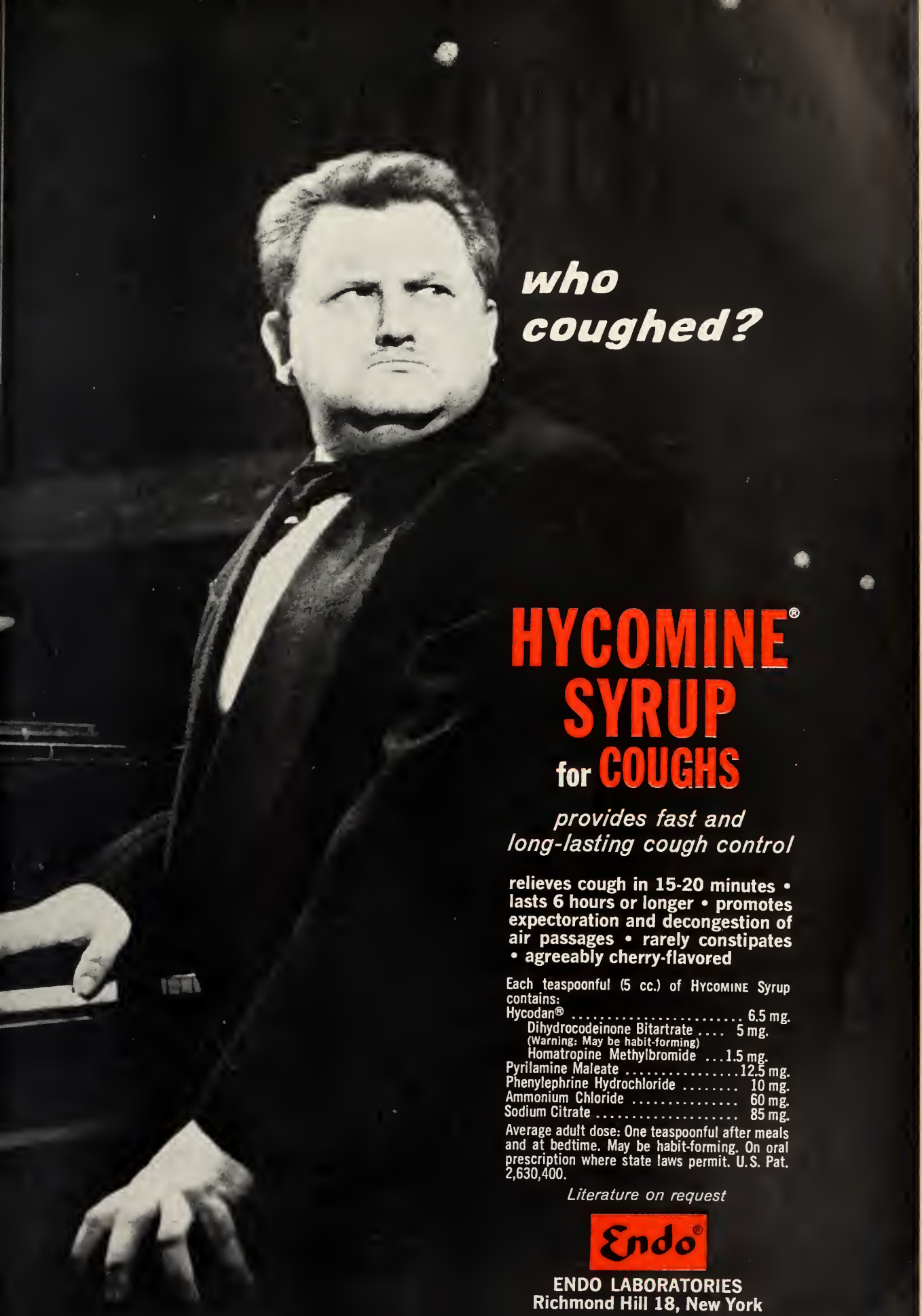
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1. **Exclusive Publication.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **Correspondence.** Address all correspondence relating to publication of scientific papers to: The Editor, The Ohio State Medical Journal, Room 1005, 79 East State Street, Columbus 15, Ohio.

3. **Manuscripts.** Manuscripts should be submitted in the original on standard 8½"x11" white typing paper. The entire text, including case reports and lists of references, should be typed double or triple space with margins of at least one inch on all sides. A copy of the manuscript should be retained by the Author.

4. **Tables and Charts.** Tables and charts that can be set in type may be included, and there will be no charge for their reproduction.

5. **Illustrations.** Illustrations requiring engraving (photographs, drawings, graphs, etc.) will be submitted to an engraver for an estimate of cost. *The Journal* will assume $25 of this expense and the Author will be billed directly by the engraver for the remainder.

Each illustration should bear the figure number and the author's name on the back. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints. Legends for the figures should be written on separate paper.

Used photographs and drawings will be returned after the article is published, if requested within 30 days after publication. Plates will be sent to the Author after the article has been published.

Obtaining permission for the taking and publishing of photographs is the responsibility of the author.

6. **References.** To conserve space and expense, lists of references should be limited to those essential to the subject and to which actual reference is made in the text.

References should be listed in the order of their appearance in the text.

Each reference should include, in this order: Author's last name and initials, title of the article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, month (day of month, if weekly), and year, e. g.

"2. Doe, J. Q., and Roe, R. X.: How to Go About It, Ohio State M. J., 13:24-30 (Feb.) 1920."

Authenticity and accuracy of references are the responsibilities of the Author.

7. **Identification of Patients.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

8. **Reprints.** An order blank for reprints with a table covering cost will be sent with the galley proof to the senior author.

Requests for reprints should be addressed to the Author.

9. **Editorial Assistance.** *The Journal* Staff is anxious to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as "Medical Writing — the Technique and the Art," by Morris Fishbein, M. D., Blakiston Division, McGraw-Hill Book Company, Inc., 330 West 42nd Street, New York 36, New York.

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LICKING—Lawrence H. Miller, President, 205 S. Prospect St., Granville; James A. Quinn, Jr., Secretary, Newark Hospital, Newark. Last Tuesday, monthly.

## County Societies' Officers and Meeting Dates (Continued)

MORGAN—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta. Called Meetings.

MUSKINGUM—Rankin A. Nebinger, President, Third St., Roseville; Benjamin W. Gilliotte, Secretary, 821 Market St., Zanesville. 1st Tuesday, monthly.

NOBLE—Frederick M. Cox, President, First National Bank Bldg., Caldwell; Edward G. Ditch, Secretary, 415 Main St., Caldwell. 1st Tuesday, monthly.

PERRY—Sydney N. Lord, President, E. Main St., Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—Clarence E. Ash, President, Marietta Memorial Hospital, Marietta; Tuathal P. O'Maille, Secretary, Marietta Memorial Hospital, Marietta. 2nd Wednesday, monthly.

### NINTH DISTRICT

GALLIA—Norman W. Pinschmidt, President, The Gallipolis Clinic, Gallipolis; Thomas P. Price, Jr., Secretary, The Holzer Clinic, Gallipolis. Last Thursday, monthly.

HOCKING—John W. Doering, President, 42 N. Spring St., Logan; Howard M. Boocks, Secretary, Court House, Logan. Called meetings.

JACKSON—John M. Cook, President, Oak Hill Hospital, Oak Hill; Brinton J. Allison, Secretary, Court House, Jackson. Called meetings.

LAWRENCE—Ralph F. Massie, President, 408 Washington St., Ironton; George Newton Spears, Secretary, 2213 South Ninth St., Ironton. Called meetings.

MEIGS—Joseph J. Davis, President, 306 N. 2nd St., Middleport; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy. Called meetings.

PIKE—Robert M. Andre, President, Lake White, Rt. 2, Waverly; Kenneth Wilkinson, Secretary, 330 E. Main St., Waverly. 1st Tuesday, monthly.

SCIOTO—Spencer W. Miller, President, 1021 9th St., Portsmouth; William E. Daehler, Secretary, 1004 24th St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President and Secretary, McArthur.

### TENTH DISTRICT

DELAWARE—Don K. Michel, President, 98 W. William St., Delaware; Edward C. Jenkins, Secretary, 470 S. Sandusky St., Delaware. 3rd Tuesday, monthly.

FAYETTE—Robert A. Heiny, President, 414 E. Court St., Washington, C. H.; James E. Rose, Secretary, 119 E. Market St., Washington C. H.

FRANKLIN—Richard L. Fulton, President, 1211 Dublin Rd., Columbus 12; Mr. William Webb, Jr., Executive Secretary, 79 E. State St., Columbus 15. 3rd Monday, monthly, except May, June, July and August.

KNOX—Delbert C. Schmidt, President, 205 East Chestnut St., Mt. Vernon; Richard L. Smythe, Secretary, Medical Arts Bldg., Mt. Vernon. Usually 1st Wednesday, monthly.

MADISON—Sol Maggied, President, 15 E. Pearl, West Jefferson; Charles Terrill Hay, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—William S. Deffinger, President, Marengo; Joseph P. Ingmire, 28 W. High St., Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Francis W. Anderson, President, 416 E. Main St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Swank, President, 172 E. Main St., Chillicothe; David McKell, Secretary, 60 Central Center, Chillicothe. 1st Thursday, monthly, except June, July and August.

UNION—Walter R. Burt, President, West State St., Milford Center; May B. Zaugg, Secretary, 130 N. Maple St., Marysville.

### ELEVENTH DISTRICT

ASHLAND—Paul J. Sauder, President, 1109 Eastern Ave., Ashland; William H. Rower, Secretary, 1060 Claremont Ave., Medical Arts Bldg., Ashland. 1st Friday, monthly.

ERIE—Carl R. Swanbeck, President, 1218 Cleveland Rd., Sandusky; Donald B. Cuthbertson, Secretary, 421 Wayne St., Sandusky. Alternately, 3rd Tuesday and Thursday, monthly.

HOLMES—Neven P. Stauffer, President, W. Adams St., Millersburg; Luther W. High, Secretary, 109 S. Clay St., Millersburg. 2nd Wednesday, monthly.

HURON—John V. Emery, President, Box 269, Willard; Nino M. Camardese, Secretary, 12 Benedict Ave., Norwalk. 2nd Wednesday, every other month.

LORAIN—Roy E. Hayes, President, Elyria Medical Arts Bldg., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 214 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Nevin J. M. Klotz, President, 162 Main St., Wadsworth; Leroy G. Dalheim, Secretary, 220 East Liberty St., Medina. 3rd Thursday, monthly, except July and August.

RICHLAND—C. Karl Kuehne, President, 480 Glessner Ave., Mansfield; Carroll E. Damron, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—G. G. Stitzinger, President, 1800 Beall Ave., Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday, monthly.

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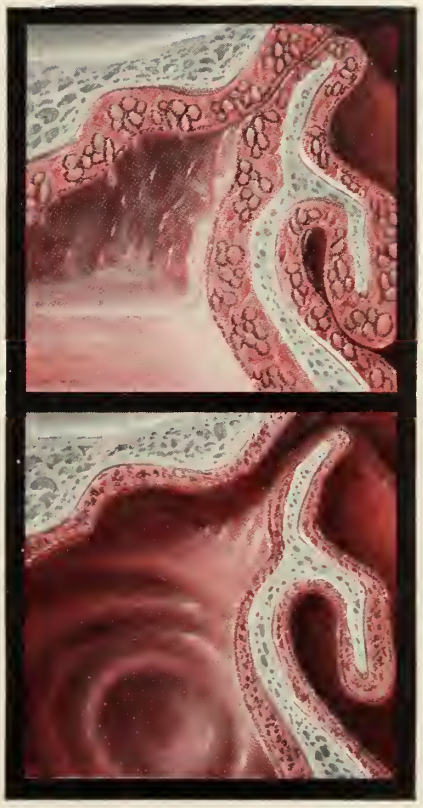
*REFERENCES: (1) Roseman, E.:* Neurology **11**:*912, 1961. (2) Bray, P. F.:* Pediatrics **23**:*151, 1959. (3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.:* M. Clin. North America **42**:*317, 1958. (5) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (6) Ibid.:* Postgrad. Med. **20**:*584, 1956. (7) Merritt, H. H.:* Brit. M. J. **1**:*666, 1958. (8) Carter, C. H.:* Arch. Neurol. & Psychiat. **79**:*136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, p. 37. (10) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1956, p. 187.*

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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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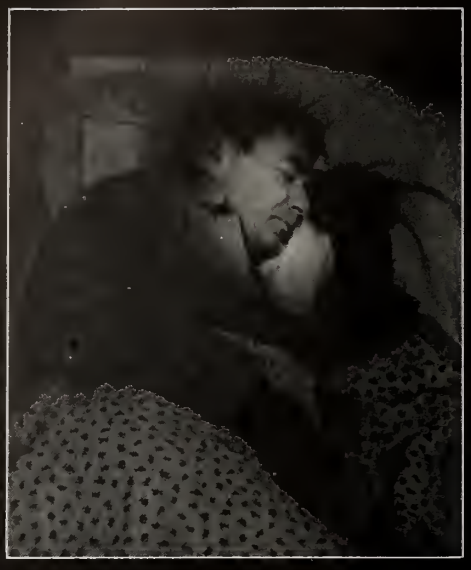
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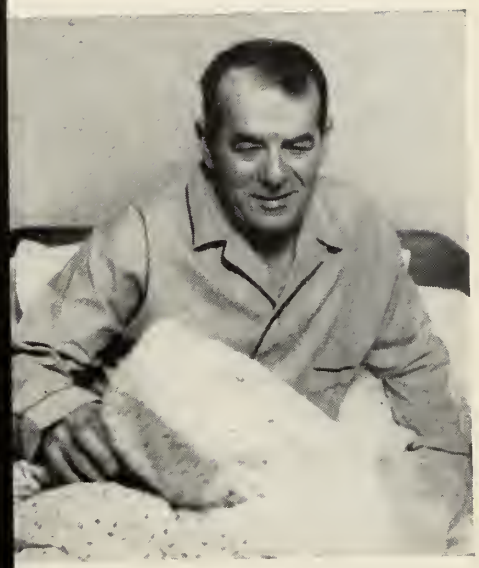


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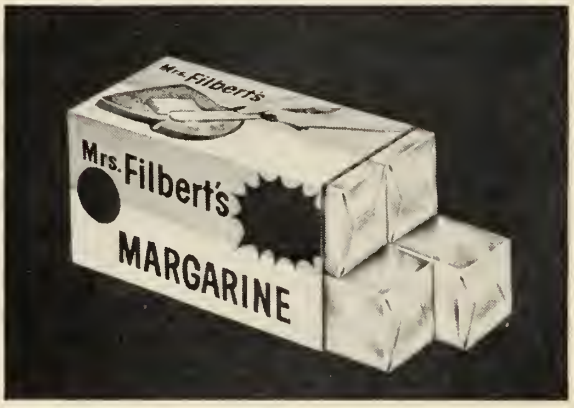
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Moreover, when you recommend any one of Mrs. Filbert's Margarines, your patient is assured of unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181: 411-423 (August 4, 1962).




**Mrs. Filbert's Corn Oil Margarine** is made from 100% corn oil, over 50% of which retains its *liquid* characteristics. Because of its high linoleic content, its ratio of polyunsaturates to saturates exceeds 1.5 to 1 . . . and equals the highest level available today in *any* corn oil margarine. Of the total fatty-acid content, 28% is cis-cis linoleic acid. Thus, it can be most useful in a program for reducing serum cholesterol levels.




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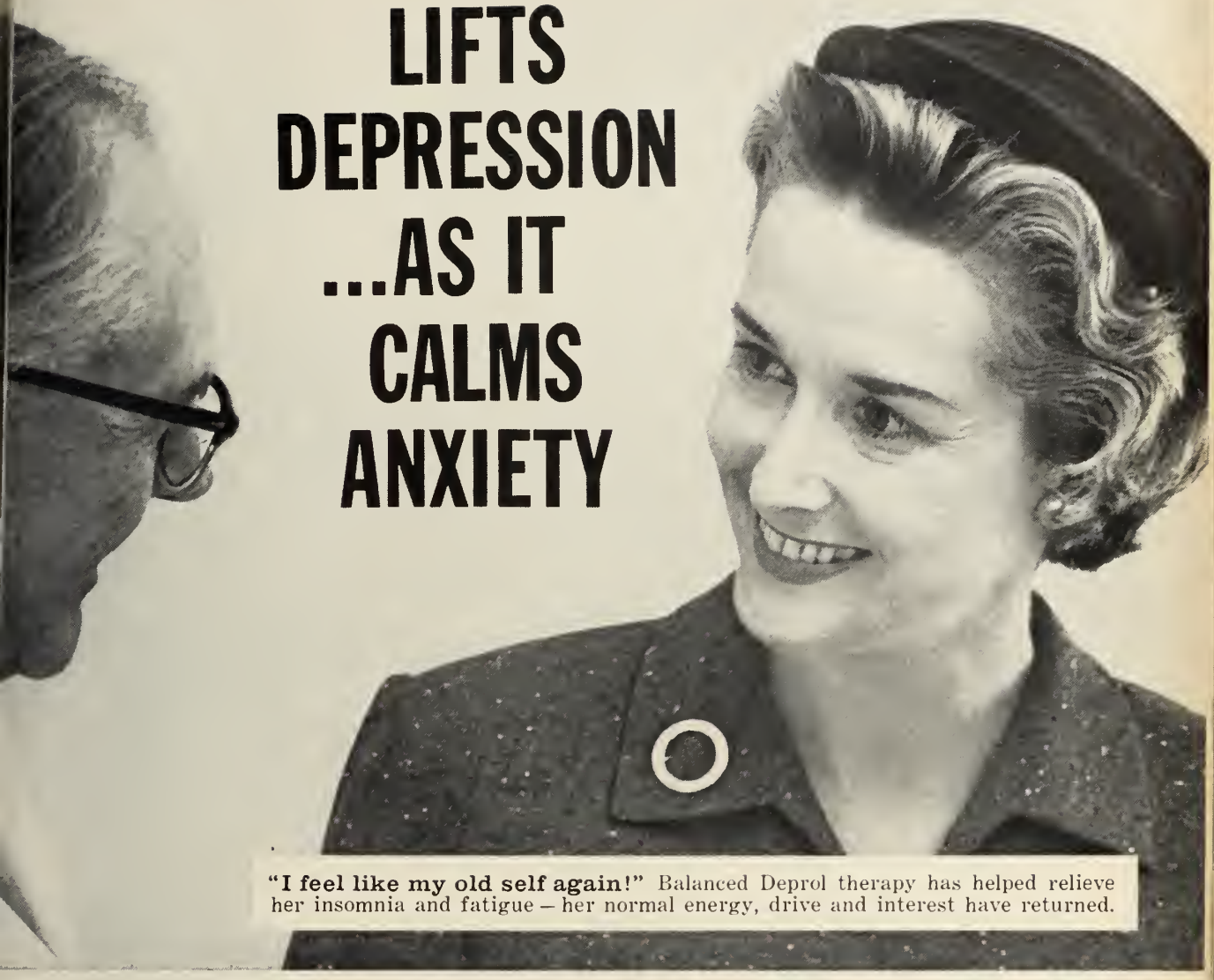

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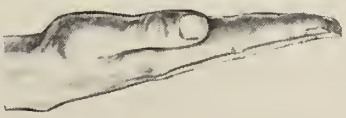
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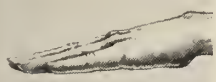
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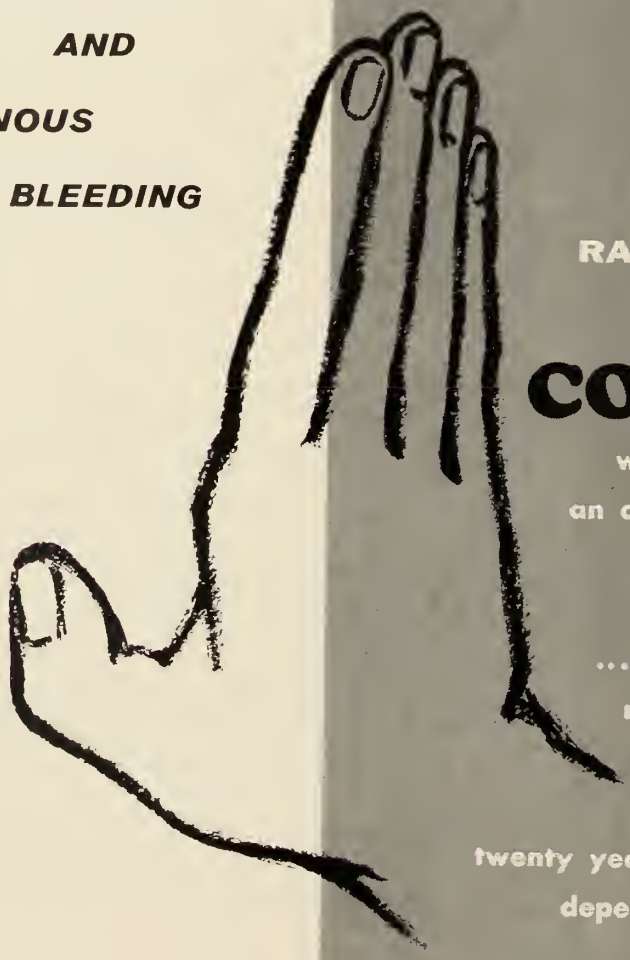
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1. *Methyltestostcrone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No. 2, February, 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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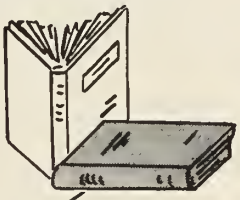
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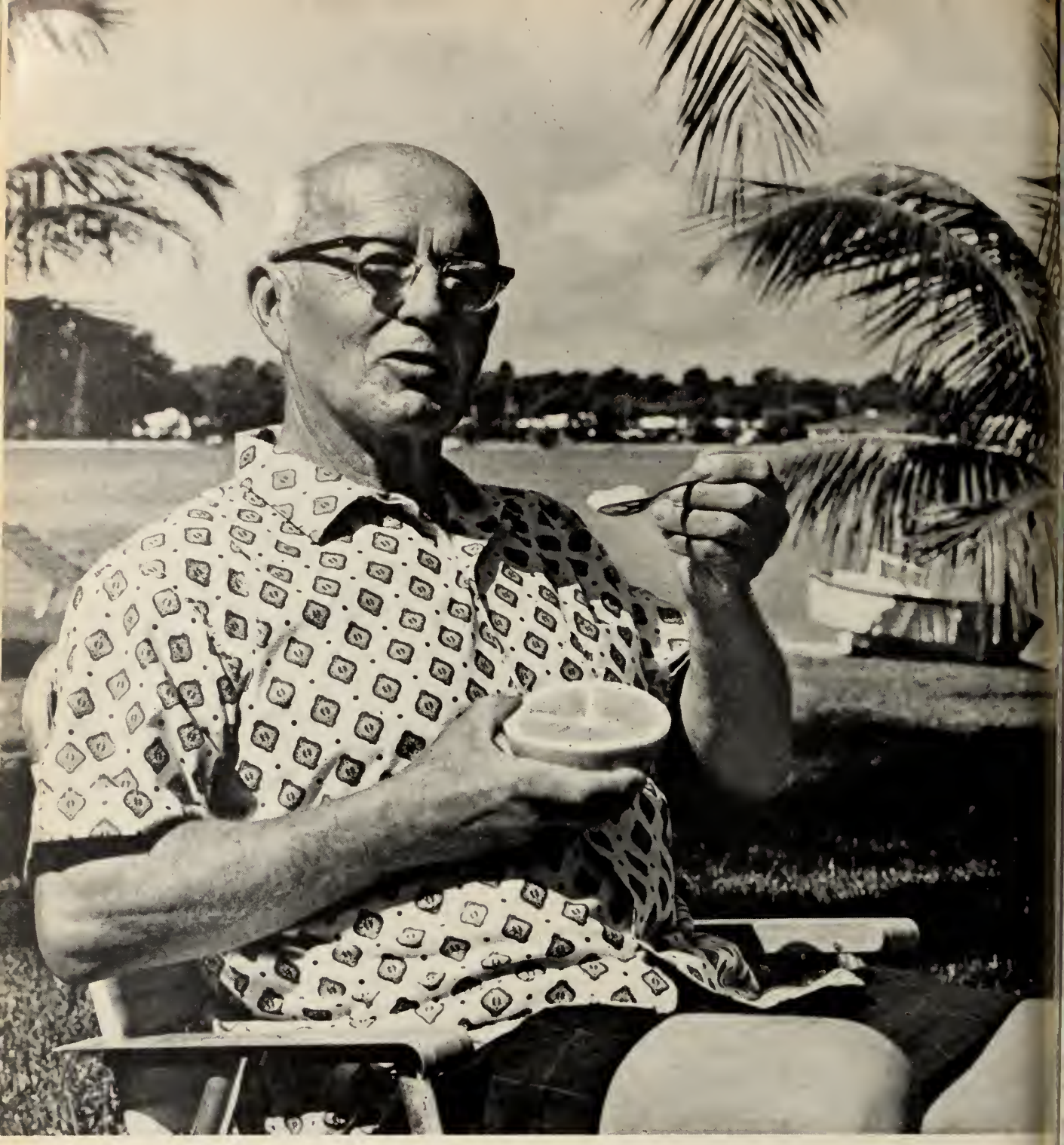
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| Meticorten® (brand of prednisone) / the classic steroid therapy | 0.75 mg. |
| Acetylsalicylic acid / for anti-inflammatory-analgesic action | 325 mg. |
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For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, New Jersey.

Bibliography: 1. Cohen, A., et al.: J.A.M.A. 165:225, 1957. 2. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 3. Moravec, C. L. and Moravec, M. E.: Clin. Med. 7:2322, 1960. H-416

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# The good life–just what the doctor ordered

Sea and sun are both in his doctor's orders — so is that grapefruit he's eating with such gusto. Citrus fruit is a wonderful way for this patient or any patient to get his daily quota of vitamin C . . . to enjoy something good to eat, tasty and satisfying but not rich.

Not all patients are so lucky as to have retired to Florida, where they can just reach out to pick citrus fruit off their own orange and grapefruit trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

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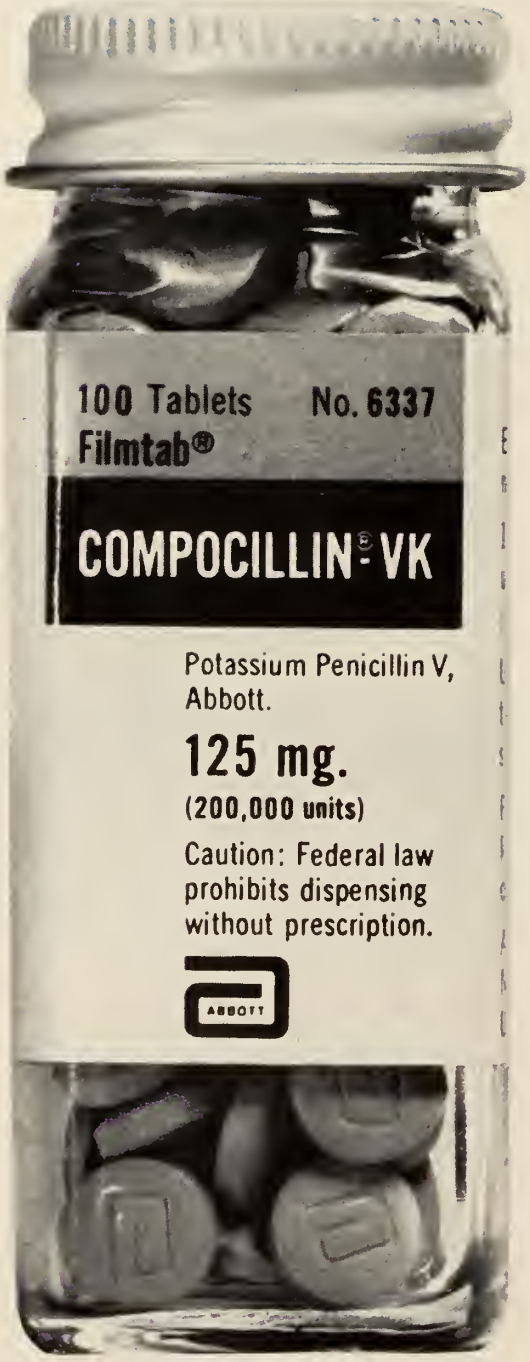



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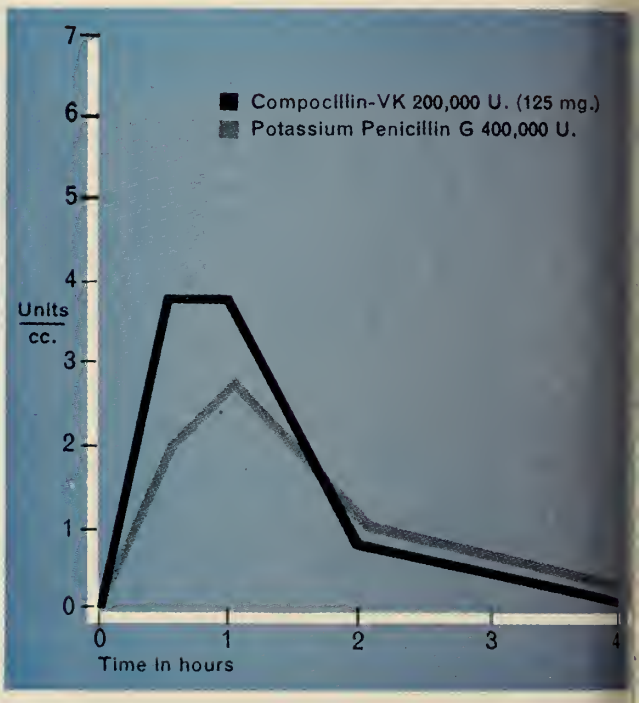
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Here's a penicillin that gives you...

# PATIENT ECONOMY WHEN YOU WANT IT




**Single Oral Doses to Fasting Subjects***



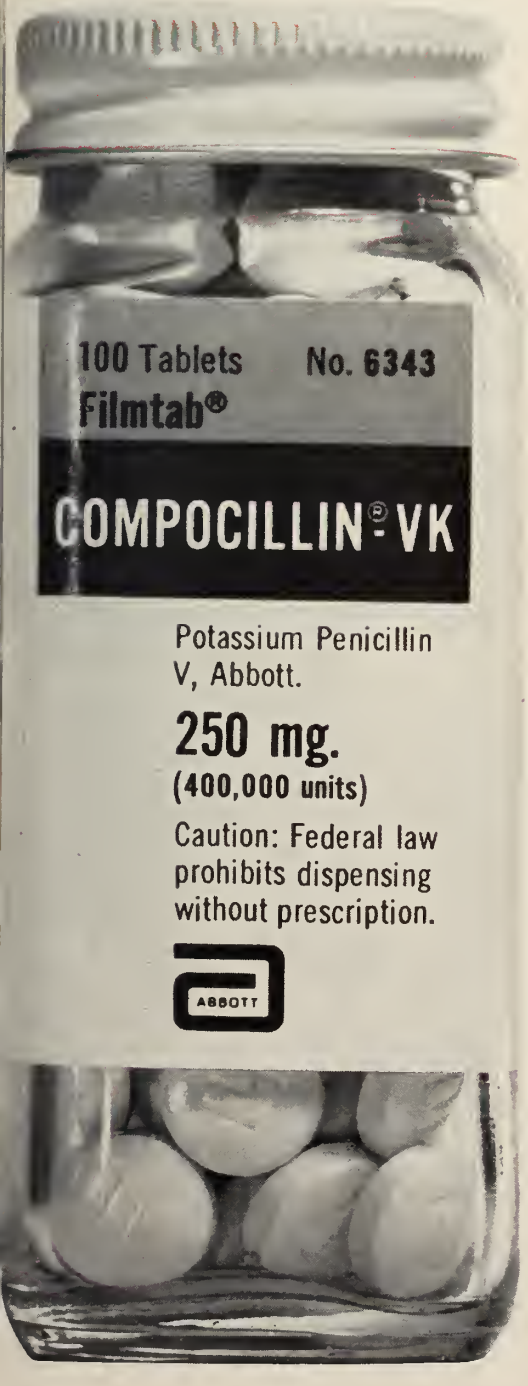

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An example might be a respiratory infection Here economy could be a definite factor ir your thinking. In the chart above, you'll see that 200,000 units (125 mg.) of Compocillin VK produces blood levels at least equal to those obtained with 400,000 units of oral penicillin G potassium. This means that in less severe infec tions, Compocillin-VK may be given at *half* the dosage needed with oral penicillin G—with no sacrifice in blood levels. In these cases, the cos of Compocillin-VK therapy will be no more— and often will be less—than treatment with ora penicillin G.

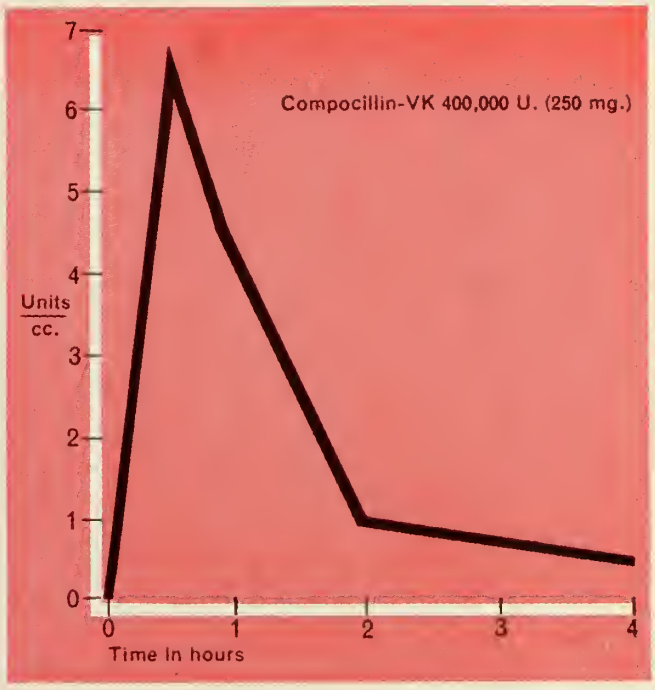
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*Chart data from two separate studies completed by the Microbiologic and Medical Departments of Abbott Laboratories.

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# *Trocinate*®

Brand of Thiphenamil HCl.

*FOR DIVERTICULITIS, MUCUS COLITIS,*

*IRRITATIVE DIARRHEA, IRRITATIVE URETERITIS,*

*BLADDER SPASM*

*T*rocinate is a musculotropic antispasmodic with no appreciable anticholinergic action. It relieves spasms of the lower bowel and genito-urinary tract by direct action on the contractile mechanism of smooth muscles. The absence of any appreciable action on the autonomic nervous system eliminates the usual side-effects. It may be safely used in glaucoma. Each tablet contains 100 mgs. Trocinate HCl.

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*Dispensed in bottles of 40 and 250 tablets.*

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*Supplied:* Flavored granules for suspension, in 30 cc. bottles with dropper-stopper calibrated in ¼ and ½ teaspoonful graduations. After mixing and shaking with 25 cc. water, each 5 cc. teaspoonful of suspension will contain:
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½ teaspoonful per 7½ to 10 pounds of body weight per day, administered in two to four equally divided doses.
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The outstanding effectiveness and record of safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom – has been clinically authenticated time and again during the past seven years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

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meprobamate (Wallace)

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***Supplied:*** 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® – 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

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1. Acts dependably – without causing ataxia or altering sexual function
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# BONADOXIN®
# for nausea and vomiting

**Confirmed in over 7 years of clinical success:** Bonadoxin stops morning sickness in 9 out of 10 patients[1]

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## time-tested for efficacy and safety

**1. Groskloss, H.H., Clancy, C.L., Healey, E.F., McCann, W.J., Maloney, F.D., Loritz, A.F.: Clinical Medicine (Sept.) 1955.**

Study involving 287 patients. 261 patients experienced excellent to good results with Bonadoxin for relief of nausea and vomiting of pregnancy. No side effects reported.[1]

**2. Albertson, H.A., Trout, Jr., H.H., Daily, F.W.: The American Journal of Surgery (Sept.) 1956.**

"As a result of this study, it is our belief that the routine prophylactic use of the combination of meclizine hydrochloride and pyridoxine is a safe and effective method for lessening the incidence of postoperative nausea and vomiting. We are employing this preparation as a routine pre-operative medication."[2]

**3. Goldsmith, J.W.: Minn. Med. (Feb.) 1957.**

Study involving 620 patients. 537 patients experienced moderate to complete improvement of nausea and vomiting of pregnancy with Bonadoxin. Toxicity and intolerance to the medication in the dosage employed in these studies was zero.[3]

**4. Codling, J.W.; Lowden, R.J.: Northwest Med. (March) 1958.**

Study involving 76 pregnant patients with nausea and vomiting. The results indicated an overall response in 70 of 76 patients treated. No side reactions were observed in this clinical study.[4]

**5. Bentley, M.D.: Journal of the Mich. State Med. Soc. (Sept.) 1959.**

[Bonadoxin] "was found clinically effective in the prevention of pre-operative and post-operative nausea and emesis in 157 patients who underwent ocular surgery, while control drugs alone could not completely eliminate the symptoms. Bonadoxin did not cause side reactions in the preoperative or postoperative phase of this study."[5]

**6. Bethea, R.C.: International Record of Med. (May) 1960.**

"Our investigation of this drug indicates that in 88 per cent of the cases satisfactory relief of the distressing symptoms of early pregnancy was obtained without undesirable side effects, including sedation."[6]

**7. Sklaroff, D.M.; Karayannis, N.: Current Therapeutic Research (June) 1962.**

"Based on these results, indicating 92 per cent effectiveness, meclizine-pyridoxine (Bonadoxin®) may be considered a valuable compound in the control of post-irradiation nausea and vomiting. The preparation proved to be safe and fast-acting in bringing therapeutic relief to carcinoma patients with radiation sickness."[7]





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Science for the World's Well-Being®

The Historian's Notebook

# The Development of Anesthesia in Ohio 1846-1961

DAVID L. FARRINGTON, M.D.* and ROBERT A. HINGSON, M.D.**

## Part II

*(Concluded from November Issue)*

CLEVELAND was not the only center experimenting with and perfecting new anesthetic technics. In Toledo Doctor E. I. McKesson was hard at work trying to improve nitrous oxide administration. In 1907 he and Doctor Moots, the Toledo surgeon, began their famous studies on the evaluation of blood pressure, pulse and respiration during surgery.[20] Doctor McKesson stressed the importance and popularized the continuous monitoring and charting of the vital signs during anesthesia. In 1910 he produced his first machine for intermittent flow nitrous oxide–oxygen anesthesia utilizing fractional rebreathing and secondary saturation technics.[21] (See Fig. 2.) Doctor Kenneth C. McCarthy states that this machine was a modified Teter.[22] McKesson became the acknowledged master of this technic and in 1915 founded the famous postgraduate school to which anesthetists flocked from all over the world for instruction and clinical experience. With Doctors F. W. Clement and Kenneth C. McCarthy he formed the first professional group for the practice of anesthesia in the Midwest.

In 1912 the Cincinnati anesthetist, Doctor Frank McMechan, was forced to give up his medical practice because of a crippling rheumatoid arthritis and his genius became directed toward his outstanding organizational and editorial abilities.[23] In 1914 he edited the *Quarterly Supplement of Anesthesia* in the *American Journal of Surgery*. This important supplement was the only professional publication devoted to the field of anesthesia for the next eight years. Doctor McMechan, confined to a wheelchair, assisted in the formation of many local and regional societies which sprung up during the next decade throughout the United States and Canada. In 1919 with the aid of McKesson and others he founded the National Anesthesia Research Society with the offices in Cleveland. This group published, in October 1922, the very first journal to be devoted exclusively to anesthesia: *Current Researches in Anesthesia and Analgesia.*

In this same year (1922) the first Congress of Anesthetists was held in Columbus, and in 1925 the Society was reorganized to form the International Anesthesia Research Society. Both the Society, with its publication *Anesthesia and Analgesia,* and the Congress are active and play important roles in keeping pace with the fast growing specialty.

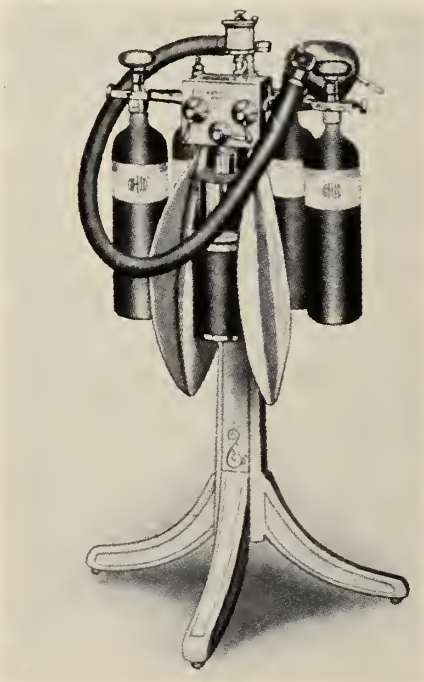


FIG. 2. *McKesson's First Gas Machine*

In 1915 Doctor Dennis Jackson of St. Louis published his classical work on carbon dioxide absorption with a closed circle for the administration of anesthesia, in the first issue of *The Journal of Laboratory and Clinical Medicine.*[24] In 1917 Doctor Jack-

*Dr. Farrington, Willoughby, is a member of the staff, Lake County Memorial Hospital, Willoughby, Ohio.

**Dr. Hingson, Cleveland, is Professor of Anesthesia, Western Reserve University School of Medicine.

Submitted August 25, 1961.

son moved to Cincinnati to continue his researches but this work passed largely unappreciated for several years although the stage was now set for the rebirth of interest in the cuffed endotracheal tube and the development of present-day carbon dioxide absorption technics.

In 1929 the Ohio Chemical Company's plant in Cleveland produced the first chemically pure cyclo-



E. I. McKesson, M. D.



Dennis Jackson, M. D.

propane for Doctor Waters, and his historic clinical trials in Madison, Wisconsin represented a major advance in the field of anesthesia.

Doctor Cecil Striker and his associates in Cincinnati[25] published their studies on the clinical use of trichlorethylene in 1935, only to be forgotten until a renewed interest during World War II by the British in their search for a nonexplosive anesthetic agent.

During this same period there developed an intense interest in the treatment of ventricular fibrillation and cardiac arrest under the leadership of Doctor Claude Beck at Lakeside Hospital in Cleveland.[26,27] Doctor Frederick Mautz in 1937 introduced procaine to reduce cardiac irritability[28] and developed the world's second mechanical ventilator for clinical use in the treatment of apnea[29] (Fig. 3). This method was soon applied to automatic ventilation of the lungs during thoracic surgery and now enjoys widespread use in other forms of surgery as well. A further development in automatic ventilation of the lungs occurred in 1948, when the Rand-Wolfe respirator was devised — a machine designed to run on electric current instead of the less readily available compressed gas.[30]

Further advances include the work of Doctors Gardner and Hale of the Cleveland Clinic, who laid the basic groundwork for the development of hypotensive technics in anesthesia when they pioneered in the clinical use of arteriotomy for the production of a bloodless field in brain surgery in 1946.[31,32] This method was widely used until supplanted by other technics. It is also of interest that it was following a suggestion of Doctor Crile in 1938 that Gillies of Edinburgh developed the technic of hypotensive anesthesia, utilizing a high spinal anesthetic in 1948.[33]

Of more recent development has been Hingson's work in the field of resuscitation and his design of an easily portable resuscitation and anesthesia machine,[34] which for the first time has made instantaneous oxygen therapy available in thumb-sized cylinders. This apparatus is also adaptable for use with a non-flammable, cyclopropane-oxygen-helium mixture for use in outpatient clinics and in the remote undeveloped areas of the world. Since 1960 Fluothane® (bromochlorotrifluoroethane) in measured 2 cc. liquid volumes has been used with this machine using 6½ liters of pure oxygen as a vehicle to produce dental anesthesia in two minutes without complications.[35]

The expansion of physician anesthesia in Ohio during the past 50 years has been phenomenal. In the year 1912 there were three Ohio physicians listed in the *American Medical Association Directory* as specialists in anesthesia; thirty-five years ago there were 53; ten years ago there were 175 active practitioners. Today there are 840 physicians in the state who administer anesthesia; 440 are members of the American Society of Anesthesiologists and 120 are board certified.

The residency training programs have likewise grown. Although Doctor McKesson conducted short

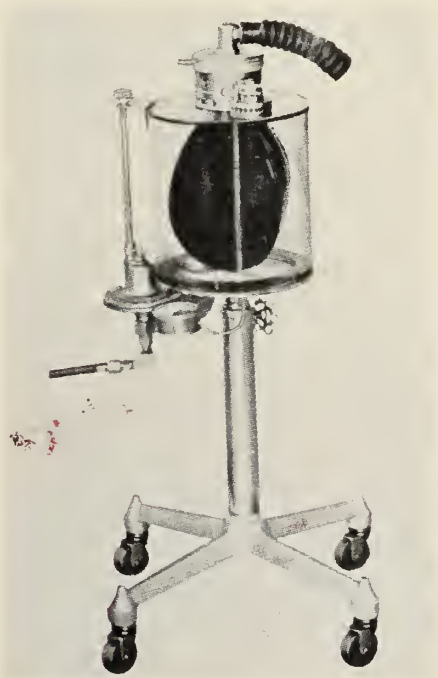


FIG. 3. *Mautz Automatic Ventilator*

informal courses in Toledo in 1915, it was not until 1936 that Doctor Rolland Whitacre established the first residency training program in the state at Huron Road Hospital, Cleveland, with Doctor Kenneth Potter as his first resident. By the year 1948 there were 12 approved programs with 19 trainees. Today, a

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When arthritis afflicts the elderly, it often poses a critical problem in the choice of an effective antiarthritic that will not aggravate other common geriatric conditions . . such as osteoporosis, hypertension, edema, hyperglycemia, peptic ulcer, renal, cardiac or hepatic damage, latent chronic infection, or emotional instability.

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Yet Pabalate-SF is marked by distinctive safety factors: its potassium salts cannot contribute to sodium retention its enteric coating assures gastric tolerance . . . and its clinical record reflects none of the serious reactions frequently precipitated by therapy with corticosteroids or pyrazolone derivatives. **It has no contraindications except personal idiosyncrasy.**

1 Ford, R A , and Blanchard, K Journal Lancet 78 185 1958

Formula: In each persian rose enteric-coated tablet: potassium salicylate 0 3 Gm , potassium para amino benzoate 0 3 Gm , ascorbic acid 50 0 mg

Also available:
**PABALATE,** when sodium salts are permissible
**PABALATE-HC,** for conservative steroid therapy

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*– the new, convenient way to prescribe* **PABALATE-SODIUM FREE**



short 13 years later, there are 17 approved programs throughout the state, the second highest in the country, with 104 resident positions available. Of the more than 530,000 anesthetics administered in the state during the past year, 150,000 were administered in the hospitals having resident training programs.

The academic phase of anesthesia teaching and research was reinforced by the appointment in 1949 of Doctor Jay J. Jacoby at Ohio State University as the first Professor of Anesthesia in Ohio, the appointment of Doctor Robert A. Hingson, as Professor of Anesthesia at Western Reserve University in 1951, and by the appointment of Doctor Arthur Ogden as Professor of Anesthesia at the University of Cincinnati in 1960. Thus, there have been developed active approved departments of anesthesiology in the three medical schools in the state.

A further example of Ohio's influence upon the national development of anesthesia worthy of note, is that 5 of the past 25 presidents of the American Society of Anesthesiologists have been Ohio born: 1945, Ralph M. Waters; 1949, H. Boyd Stewart; 1950, Rolland J. Whitacre; 1955, B. B. Sankey; 1959, Daniel Moore. Many contributions have come from Ohio which have helped in no small way to make the specialty of anesthesia a strong member of the medical profession. Ohio has a firm foundation upon which to build for the future.

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35. Work in progress.


THIRD PHASE OF MEDICAL RESPONSIBILITY.— I am one who does not believe in compulsory retirement. I don't know where the magic age of 65 came from. I have a figment in my own mind that I think it must have happened this way: in a small corporation some place on the eastern seaboard they had a directors' meeting. The President was very unpopular. He was absent that day and somebody remembered it was his birthday so they passed a rule that there would be compulsory retirement at 65. That's the most logical thing I can think of — since we all know that age is physiological and not chronological, that some people should retire at 50 and others are very capable at 80.

It is interesting to recall that if Mr. Churchill had retired at age 65 it would have been just a few months before the battle of Britain, and history might have been written somewhat differently.

You can't tell me that in a population that has learned to split the atom and do what we have done with electronics and antibiotics and psychiatry that there can't be a means developed whereby it would be possible to pick those who, if they so desire, could stay on and work if they are needed, who could work part time, who could change their occupation, who could be consultants or could do another job.— Howard A. Rusk, M. D., New York: in *Your Physician Looks at Health and Productivity*. The American College of Physicians, Philadelphia 4, Pa.

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prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis



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| Pectin N.F. | 225 mg. |
| Kaolin | 3 Gm. |
| Opium tincture U.S.P. | 0.08 cc. |
| (equivalent to 2 cc. paregoric) | |

**DOSAGE:** Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

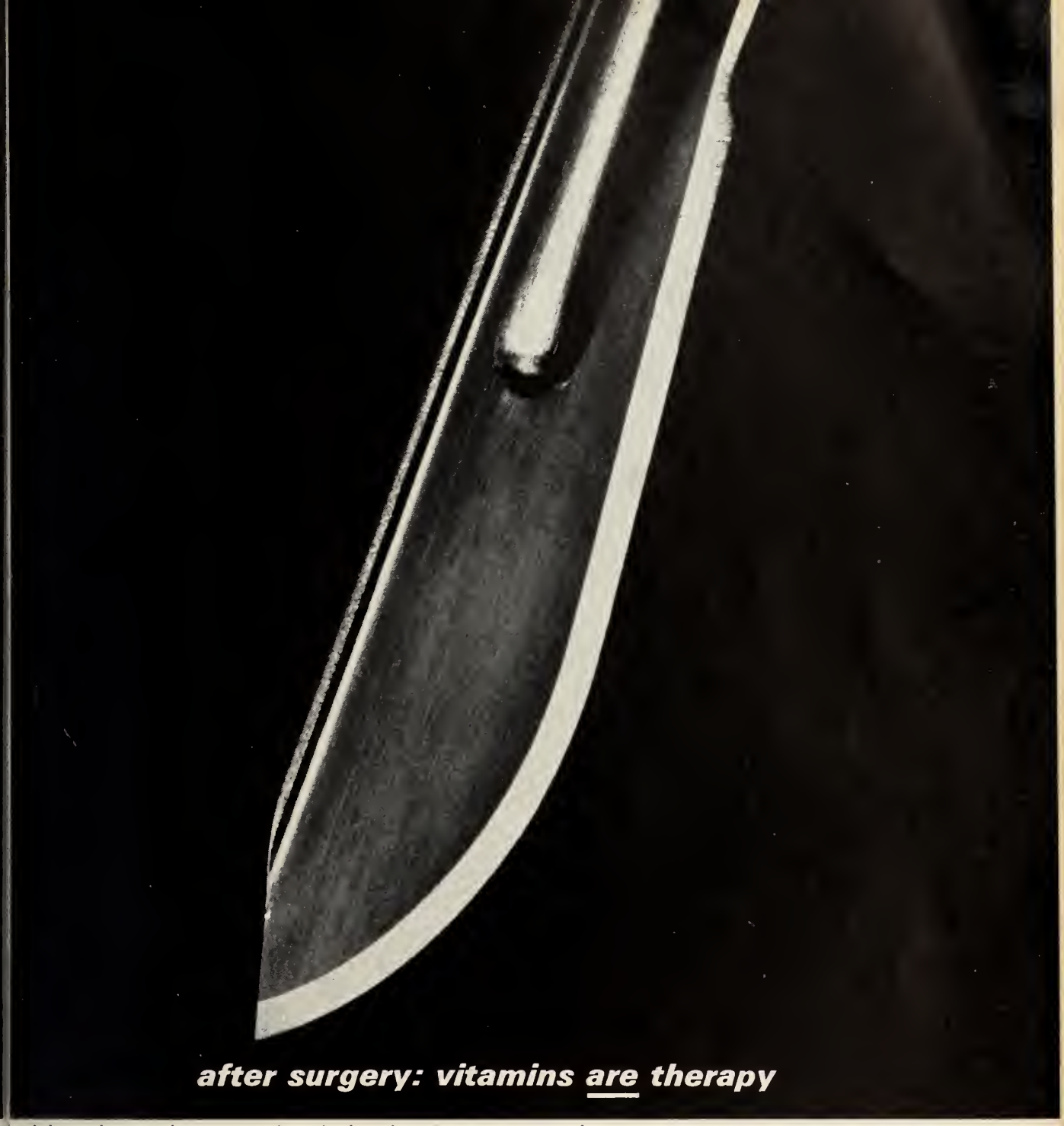
Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

**SUPPLIED:** *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
*Exempt Narcotic. Available on Prescription Only.*

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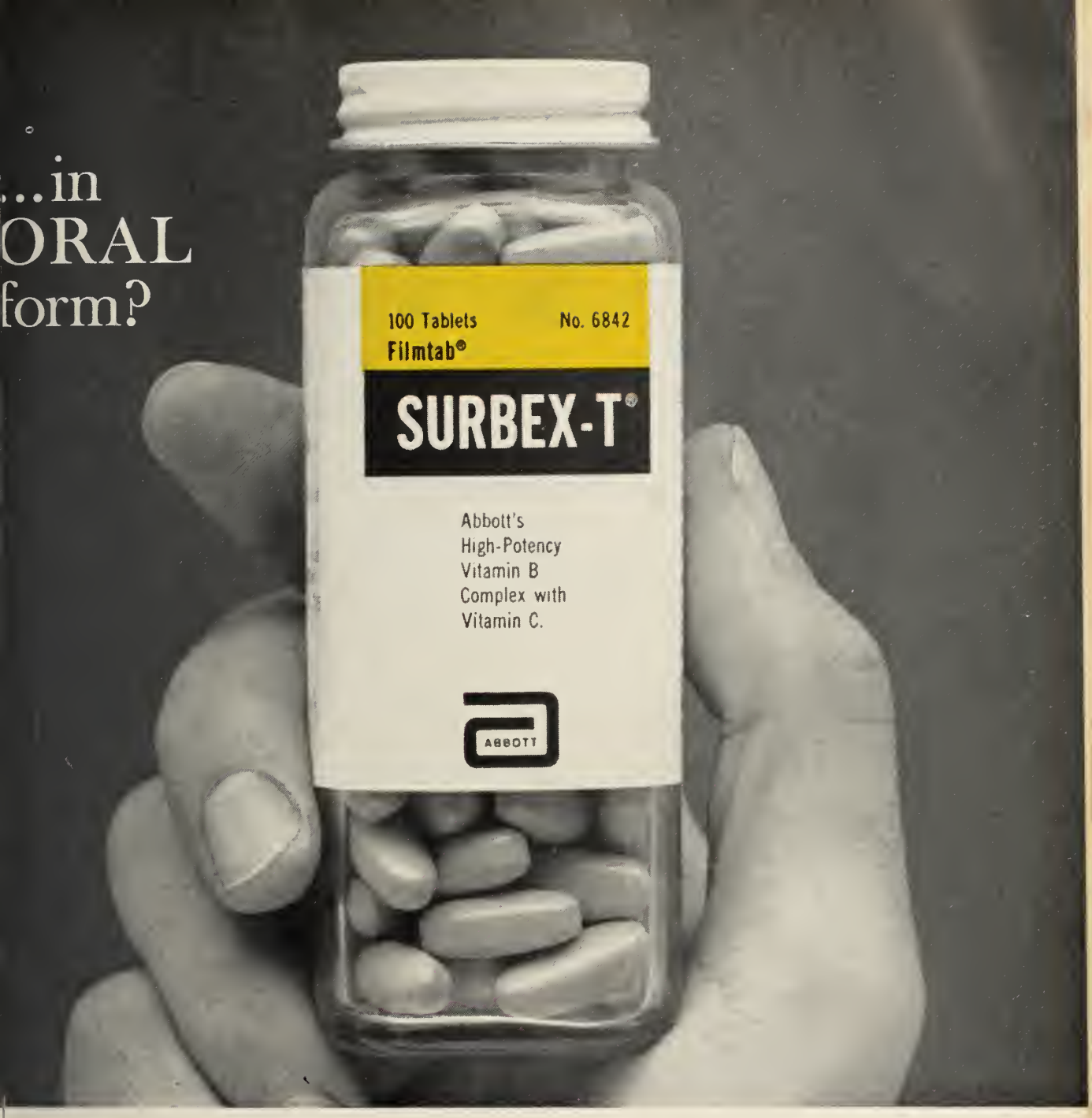
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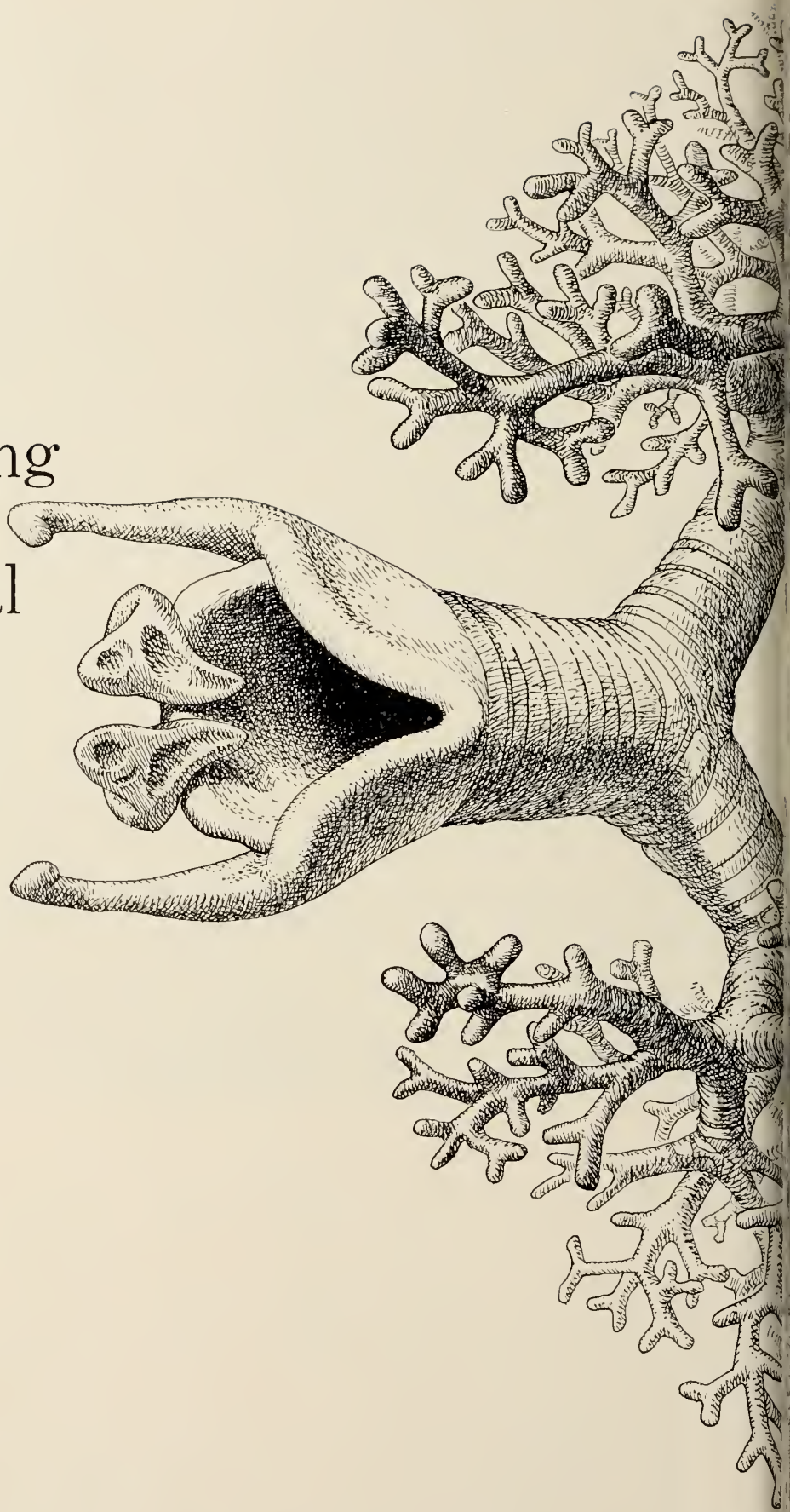
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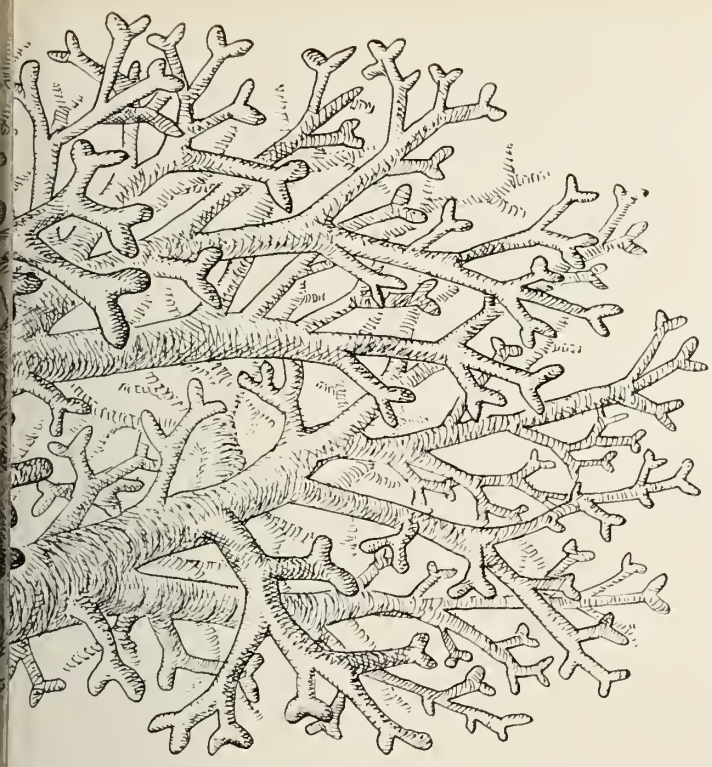
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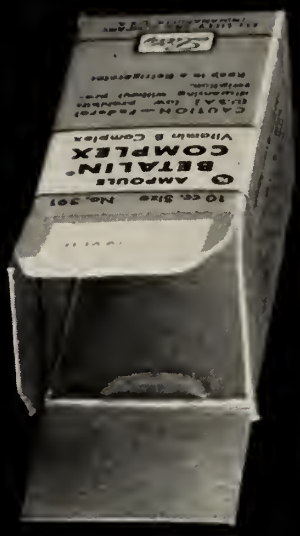
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VOL. 58 DECEMBER, 1962 NO. 12

# The Burn Wound

JAMES E. BENNETT, M.D.

EARLY management of the burn patient has improved considerably during the past 15 years and deaths during the "shock phase" are now uncommon. Universal understanding regarding local treatment of the burn wound has not been achieved, however. Sustained, aggressive therapy is required, and the burn should be kept as clean as possible to facilitate healing of partial thickness segments and to prepare areas of full thickness loss for skin grafting.

## Early Wound Care

The full thickness burn can be prepared for initial grafting by frequent cleansing and dressing changes. These procedures should be performed in the operating room every two or three days, beginning early in the second week. Inhalation analgesia with nitrous oxide–oxygen and/or fluothane is usually sufficient to permit cleansing and dressing. This routine can often be observed without the usual pre-anesthetic period of withheld nourishment — an important factor in the severe burn.

During the third week (or perhaps earlier when occlusive dressings are used) the eschar begins to separate. This process should be aided by gentle debridement. Areas of full thickness loss will present as open wounds during this period and should not be left exposed after cleansing. A single layer of fine mesh gauze — dry, moist or impregnated with glycerin or Furacin® — will often suffice as the dressing. Limbs usually require occlusive bandages. These dressings should be bulky and homogenous and should be applied with care. The wound is ready for grafting when it presents a flat, red, firm, granulating surface.

Submitted January 28, 1962.

*The Author*

● **Dr. Bennett, Columbus, is assistant professor of surgery and director of the Plastic Surgery Division, The Ohio State University.**

## Skin Grafting

The Brown electric dermatome has greatly simplified skin grafting of burn patients. Grafts should be thin to intermediate (0.008 to 0.014 inches), depending on the age of the patient, the availability of skin, and the area to be grafted. The skin should be placed on the wounds in strips as they are taken with the dermatome, observing natural skin lines. They should be applied close together, avoiding wide avenues of granulation between the grafts. Skin grafts rapidly adhere to a suitable granulating bed and suturing of the skin is rarely necessary. Pinch grafts should not be used, and the decimation of sheets or strips of skin into tiny postage stamp segments is seldom indicated.

Donor sites are dressed with a single layer of fine mesh gauze. Temporary application of a moist pack over the fine mesh gauze is usually sufficient to obtain hemostasis.

Grafted parts may be exposed or dressed. When the former technique is used, all residual ungrafted areas, no matter how small, should be covered with a single layer of fine mesh gauze. The exposure of skin grafts allows frequent inspection. Small collec-

tions of blood and areas of purulence can be evacuated as necessary. The cool dry environment of the atmosphere may be significant when compared to the increased temperature beneath an occlusive dressing. The inherent disadvantage of graft exposure, particularly in children, is the absence of an immobilizing force which a proper dressing provides. Adequate restraints and indulgent observation usually overcome this drawback.

As in the pre-graft stage, occlusive dressings should be even, voluminous, and snug. The first layer should be of fine mesh gauze to minimize growth of residual granulations through the interstices. The part should be dressed in the position of function. Little is gained by deferring the first post-graft dressing change beyond four days.

Physiotherapy should begin on the day of burn. Active and passive exercises of the unburned parts are most important. Isometric movements of burned limbs are helpful. Positioning of the patient and his various parts should receive constant attention. Burned limbs must be positioned so that they are above cardiac level. Except with burns "minor" in depth and/or extent, immersion baths should be reserved for the final stages when raw surfaces are small. Early ambulation is usually encouraged. When lower limbs are involved, however, they should not be allowed in a dependent position until healing is complete and then only with supportive bandages.

Healing of the burn wound is facilitated by adequate systemic therapy, prevention of exudative or invasive infection, and early skin grafting. Greasy ointments, exotic sprays and other applications do not promote healing; in fact, they often interfere with normal processes of resolution and re-epithelialization. While early excision of full thickness burns with immediate grafting has occasionally been successful in the hands of experts, this course of management cannot at this time be recommended for general use. Further experience with this method may show an increased salvage rate among severe burns, but it is doubtful that the method will enjoy universal application. The same reasoning applies to skin grafting on the non-granulating surface which presents at the end of the second week in full thickness burns that have been covered by occlusive dressings. Experience has shown that waiting for an ideal granulating surface is worthwhile, particularly since the percentage of graft take at the first operative procedure is often the most influential determinant of healing time and hospital stay.

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**ASIAN FLU EPIDEMIC EXPECTED.**—The Surgeon General's Advisory Committee reminds of the possibility of increased incidence of influenza during the coming winter months. In recent years this disease has caused much illness and considerable mortality in our population.

While accurate predictions are difficult, recent and past patterns of influenza A and B indicate that outbreaks of influenza $A_2$ (Asian) are likely to occur in the United States during the 1962-63 winter season. Outbreaks of influenza B may be expected to be infrequent. On the basis of presently available information, no change is warranted in either A or B strains in the vaccine.

It was suggested that public health departments enlist the cooperation of physicians, medical societies, and voluntary health agencies in initiating early fall campaigns for influenza vaccination of the susceptible population, now expanded to include all those over 45 years of age. As in the past, influenza vaccination will continue to be recommended for pregnant women and persons at all ages who suffer from chronic debilitating diseases. Large scale immunization programs are encouraged among personnel in medical and health services, public safety, public utilities, transportation, education, communication fields, industries, and large institutions where absenteeism is of particular concern.— Division of Communicable Diseases, Ohio Department of Health: *Disease Control Information*, Vol. IV, No. 5, October 22, 1962.

# Osteoarthritis of the Hip Joint

HERBERT KNODT, M. D.

A STUDY of the literature on the treatment of osteoarthritis of the hip joint is a depressing experience. To suggest to a patient the elimination of pain in the hip by arthrodesis or the replacement of parts by metallic bodies is a very grave decision which should not be made unless there is no other choice. Rigid metal cannot replace the yielding and pressure distributing properties of cartilage. Numerous conservative procedures are suggested in the literature, all seemingly successful in one important point: the relief of pain. This relief of pain, to be sure, is only temporary in most cases. It is certain, that any surgical procedure on an osteoarthritic hip joint — be it denervation, bone drilling, excision of the joint capsule, etc. — will relieve pain temporarily, even when some of these seem to lack any logical foundation. They possibly interrupt for some time a mechanism which maintains an increased tone of the hip musculature in osteoarthritis. Occasionally a case is reported where the relief of pain is permanent and where x-ray changes indicate a structural standstill or improvement of the degenerative process, but by and large it seemed impossible to predict the outcome in the individual case at the time of surgery with any degree of certainty.

Even more depressing are the constantly repeated statements in most articles on this subject to the effect that functional joint cartilage cannot regenerate, that a lost joint space cannot be regained, or that the degenerative process of osteoarthritis cannot be halted or reversed. Pauwels has shown that these statements are false. He has theoretically and by mechanical experimentation analyzed the problem and applied his findings in more than 350 successfully treated cases over a period of 20 years. The results achieved are little short of an elimination of the disease. I have studied his cases, assisted in the preoperative evaluation and operative procedure of some and have added a smaller series of patients with similar results.

This preliminary report is presented to outline the basic principles. Their application requires experience and strict adherence to surgical detail, the main difficulty being the correct choice of the procedure for the individual patient.

## Importance of Abnormal Load On Hip Joint

Basically the process of degenerative disease of the hip joint is progressive as long as the pressure in the joint is greater than the ability of the cartilage and bone involved to withstand it. It becomes regressive as soon as this pressure is reduced to a level that can be tolerated. This is true regardless of the etiology of the disease or the stage to which it has advanced. Since the remarkable power of regeneration of an osteoarthritic hip joint can never be initiated by an avascular femoral head, living bone must be present. We reduce the pressure in the joint by operative means, either by reducing the pressing force (hanging hip operation) or by increasing the weight transmitting area or by both (intertrochanteric osteotomy).

## Mechanics of Hip Joint

In the normal hip joint there are several factors *producing* joint pressure. In the stance phase of gait the pressure is due to the body weight (minus the weight of the supporting leg) plus the pull of the abductor musculature which balances the pelvis and body over the joint. This abductor pull can exceed the amount of the body weight more than four times and go up as high as 600 lbs. in a person of medium weight. In addition all muscles crossing the hip joint contribute to the pressure, even in recumbency, and

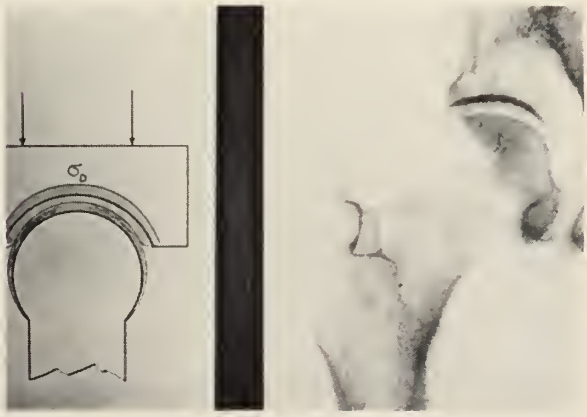



FIGURE 1

Submitted March 18, 1962.

## *The Author*

● Dr. Knodt, Columbus, is a member of attending staffs of Riverside Methodist, Mount Carmel, Grant, Mercy, and St. Anthony Hospitals; Instructor, Department of Surgery (Orthopedics), The Ohio State University College of Medicine.

particularly when the joint is painful and its structures are irritated.

Responsible for the *distribution* of the pressure in the joint are the cartilage covering the articular surfaces and the size of the weight transmitting area. Loss of cartilage reduces the size of the pressure distributing area considerably because the bony radius of the femoral head is much smaller than the bony radius of the acetabulum. It is further reduced by subluxation of the joint or any incongruity of the surfaces which reduces the area of contact.

### Response of Bone and Cartilage To Increased Load

Regulated by functional demands in living bone, new bone substance is deposited in areas under increased mechanical stress and absorbed in areas where the mechanical load is sufficiently reduced. This seems to guarantee mechanical efficiency under the most economical conditions. The function of a thermostat is comparable in nature. Cartilage apparently has no similar mechanism of regulation: if the pressure to which cartilage is subjected exceeds its tolerance it gradually becomes necrotic and disintegrates. However, cartilage has the ability to grow and regrow against pressure as long as such pressure stays within physiological limits. We know that epiphyseal cartilage grows against pressure within these limits in defiance of the so-called Hueter-Volkmann law.

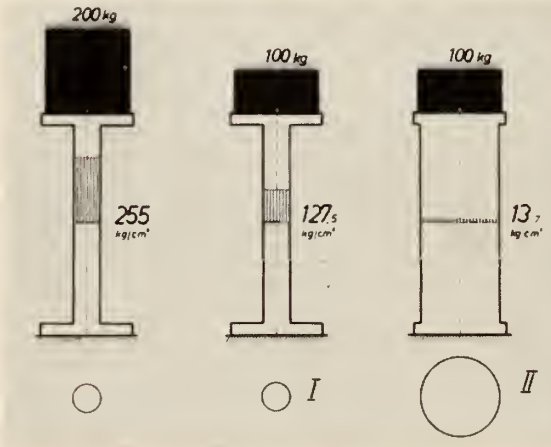



FIGURE 2



FIGURE 3



FIGURE 4

In the osteoarthritic hip joint, therefore, we see a constant battle and interplay between excess of pressure and nature's attempt to overcome it. In the areas exposed to increased pressure, cartilage disintegrates. Trabecular bone is converted into bone more reminded of cortical bone with sclerosis and loss of trabecular structures. In areas with reduced pressure, we see the development of osteophytes covered with new cartilage. After reduction of pressure by surgical intervention we observe the reversal of these changes: cartilage regrows and sclerotic bone is again converted into cancellous bone. Vascular changes in the joint structures follow these alterations in both directions. To consider these primary seems unfounded.

### Early Diagnosis

Pauwels has shown the possibility of recognizing at a very early stage the development of abnormal pressure in the hip joint. The small and even condensation of bone in the roof of the acetabulum indicates even and physiological pressure (Fig. 1). It corresponds closely to a schematic load distribution curve as seen next to the x-ray of the normal hip. Any alteration of its shape or extent indicates an alteration in the pressure or its distribution in the joint. This can be observed long before serious cartilage damage has taken place. Apparently the response of bone to increased pressure is a very fine and prompt mechanism, whereas cartilage can tolerate abnormal pressure for a considerable length of time. This makes early recognition and treatment of osteoarthritis of the hip joint possible.

After the cartilage is partially or totally lost, the subchondral bone is exposed to a further increase in pressure. It responds as previously stated by additional bone deposition, seen on roentgenograms as increased density and sclerosis. We believe the development of cysts is in keeping with the suggested transformation of trabecular bone into cortical type of bone. The pressure is now transmitted through the sclerotic bone and some trabecular areas are relieved of their mechanical function and undergo dis-

use atrophy. In the reversal of these changes after operative reduction of the pressure, trabeculae return into the cystic areas and the abnormal sclerosis disappears. It is interesting to find that the osteoarthritic femoral head has a greater cartilagenous and bony mass than its normal counterpart, quite different from the picture seen in rheumatoid or septic arthritis. This would justify the term "regenerative arthritis."

### Plan for Treatment

Every osteoarthritic hip joint presents a new and different problem awaiting mechanical correction. For this reason individual evaluation and preoperative planning are essential for a successful operation. The pressure in the joint is reduced by suitable osteotomy, which increases the weight transmitting area and reduces the force of the musculature required for motion of the joint. X-rays are taken of the joint in neutral position, in maximum abduction and maximum adduction, to visualize the position which makes the joint surfaces most parallel. This optimum position gives the greatest gain in weight transmitting area. This position is then made permanent by an intertrochanteric osteotomy. If the joint under evaluation has a significant reduction in its range of motion, the pictures are taken under general anesthesia, in some cases after adductor tenotomy. If adduction of the leg proves to be the best mechanical position, an abduction osteotomy will make it permanent. An adduction osteotomy is indicated for joints with improved mechanics in the abducted position. The distal fragment is displaced medially in both procedures.

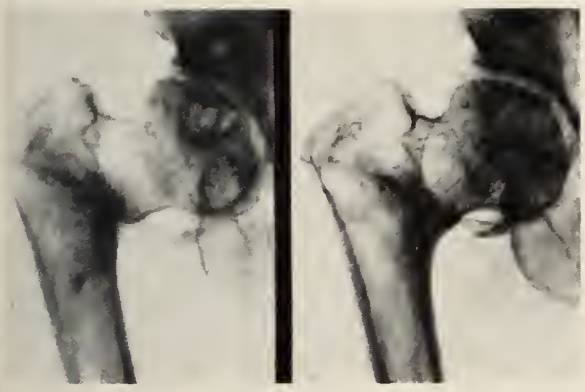
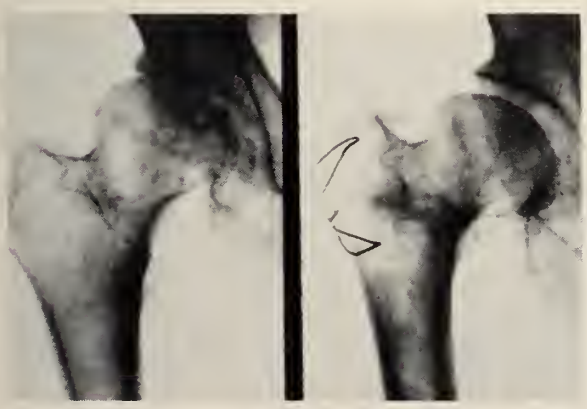


FIGURE 5



*a* *b*

FIGURE 6, *a* and *b*

The reduction of joint pressure by adduction osteotomy is accomplished by seating the head deeper into the acetabulum, by moving the greater trochanter away from the center of motion and thereby improving the leverage of the abductors balancing the pelvis with less force and by reducing the distance between origin and insertion of the iliopsoas and the adductors. After the abduction osteotomy the joint pressure is reduced by moving the lesser trochanter up, by tenotomy of the abductors or osteotomy of the greater trochanter and in both procedures by making the joint surfaces more parallel.

Figure 2 (Pauwels) shows the schematic drawing of the effects of operative procedures on the pressure in the joint. Before surgery in the left drawing we have a load of 200 kg., resulting in a pressure of 255 kg/cm.$^2$ By reducing the load to 100 kg. by the "Hanging Hip Operation," i. e. operative release of the musculature surrounding the hip joint, the pressure is reduced to 127 kg/cm.$^2$ The next drawing represents the effect of the properly selected osteotomies. Reduction in muscle pull plus a threefold increase in weight transmitting area reduces the pressure in the joint to only 13.7 kg/cm.$^2$

### Results of Therapy

Figure 3 shows two positions in a preoperative evaluation (abduction and adduction) of a 62 year old woman with painful osteoarthritis. Figure 4 is an x-ray of this hip joint eight months after adduction osteotomy; there has been no pain since her surgery. Two months ago her other hip joint was similarly treated with the same result.

In figure 5 we see the joint of a 57 year old man (Dr. Pauwels' case) on the left one year and on the right 10 years after osteotomy. Note the changes in the acetabular roof which indicate now physiological pressure distribution. Figure 6-a is the preoperative status of a hip joint of a 48 year old woman (Dr. Pauwels' case). Figure 6-b shows the same joint two years after osteotomy.

A program of conservative management of early osteoarthritis of the hip joint should apply the same principles. An active exercise program is of doubtful benefit since it increases the tone of the musculature and the pressure in the joint. Manipulation under anesthesia is more applicable and is often found beneficial. Frequent rest periods, the application of moist heat, or traction are helpful. The use of a cane reduces the pull of the abductor musculature and will most of all prolong the service of the affected hip joint.

# Regional Colitis

## A Report of Two Cases

KARL D. VENTERS, M.D., and HENRY W. BROWN, M.D.

REPORTS of many cases resembling regional colitis have appeared in the literature since 1900. Moynihan[1] and Mayo Robson[2] were two of the early investigators of this problem. Bargen and Weber[3] in 1930 reported 23 cases treated medically. They considered regional colitis a form of ulcerative colitis and cautioned against confusing it with tuberculosis of the colon. In 1932 Crohn[4] described a nonspecific granulomatous lesion with submucosal thickening and mucosal ulceration involving segments of both colon and terminal ileum. He separated this entity, which now bears his name, from regional ileitis. Bargen and many others interested in ulcerative colitis described a specific pattern of segmental or regional localization in about 10 per cent of all cases of chronic ulcerative colitis. These lesions resemble, clinically and pathologically, those described by Crohn and earlier workers.

Symptomatically, these patients present malaise and chronic, irregular diarrhea often associated with lower abdominal pain and passage of blood or mucus. Weight loss, anorexia, and night sweats are common. The onset of illness is often timed with an emotional or physical stress, and these patients characteristically are tense and anxious. Physically, they are pale and anemic, and they frequently exhibit malnutrition and hypoproteinemia. In long-standing problems or in recurrent episodes, anorectal abscesses, fissures, and fistulas are seen.

Brownlee[5] and Brooke[6] have reported segmental lesions of colon resembling ulcerative colitis producing an acute surgical abdomen. Clinically, these problems have been confused with obstructing carcinoma of the colon, acute gastric perforation, and mesenteric artery thrombosis.

Following, we report two patients with segmental obstruction of the colon due to a nonspecific granulomatous lesion having submucosal thickening and mucosal ulceration. One patient presented an obstructing carcinoma of the left colon, while the other had an obstruction of the left transverse colon initially and has required two subsequent colon resections for recurrences.

### Case 1

A 54 year old man was admitted to the hospital on July 12, 1960, with a two week history of diarrhea that had been bloody for the past five days. There was no previous history of gastrointestinal symptoms. On admission he was complaining of diffuse cramp-like lower abdominal pain without nausea and vomiting. He had lost 5 to 7 lbs. in the two week period of illness.

On physical examination, blood pressure was 140/82; pulse rate 88 per minute; and respiratory rate 20 per minute. The patient was tense and anxious. Abdominal examination revealed tenderness in the lower abdomen bilaterally but no rebound. Rectal examination failed to reveal a mass, and the prostate gland was normal. There was no fissure nor fistula. The stool on the examining finger gave a 4 plus Guaiac reaction. Laboratory examination revealed: red blood cell count 3,702,000; white blood cell count 10,760; sedimentation rate 42 mm/hr. X-ray examination revealed an obstructing lesion at the mid-portion of the left colon resembling carcinoma. Proctosigmoidoscopic examination was normal for a distance of 25 cm.

At operation, a constrictive lesion 8.0 cm. long was found at the mid-portion of the left colon. The mass was firm and regular. Its serosal surface was red-tan in color with marked vascular congestion. On cut-section, the mucosa was ulcerated in the central portion of the lesion and at the periphery somewhat hypertrophied. The entire bowel wall in this area was thickened to approximately 3.0 cm. Several mesenteric nodes were found. The mass was resected widely, and end-to-end anastomosis was performed. The postoperative course was uneventful.

Microscopic examination of the resected specimen demonstrated an ulcerative lesion of a colon segment. The submucosa was thickened with fibrosis and granulations. There was ulceration of the mucosa, and some areas evidenced polypoid and hyperplastic changes. Heavy infiltration of both mucosa and submucosa with polymorphonuclear leukocytes and plasma cells was noted, and an occasional multinucleated giant cell was seen.

### Case 2

A 45 year old brick mason was admitted in March, 1951, with malaise, weight loss, and diarrhea of three months duration. On admission, he was having 8 to 10 bloody stools a day and severe, cramp-like lower abdominal pain. He had a hypochromic anemia but otherwise was in good physical condition. X-ray examination revealed a constrictive lesion of the mid-transverse colon. Sigmoidoscopic examination was negative to 25 cm. The colon lesion was resected and an end-to-end anastomosis performed.

Microscopic examination of the lesion revealed mucosal ulceration, thickening of the submucosa by granulations and fibrosis, and infiltration of the bowel wall by polymorphonu-


### *The Authors*

- **Dr. Venters, Centralia, Illinois, is staff surgeon at St. Mary's Hospital in Centralia.**
- **Dr. Brown, Cleveland, is chief of staff and director of Surgery, Huron Road Hospital, and on courtesy staff, St. Luke's Hospital.**


From the Department of Surgery, Huron Road Hospital, East Cleveland, Ohio. Submitted January 16, 1962.

clear leukocytes and red blood cells. Lymph nodes resected with the specimen showed large follicles with much edema and polymorphonuclear leukocytic infiltration.

In February, 1952, he was readmitted with a recurrence of symptoms and marked weight loss. He was extremely tense and nervous. X-ray examination revealed a constricting lesion of the upper left colon. A resection of 28 cm. of the left colon with end-to-end anastomosis was performed. The microscopic picture was identical with the previous lesion. He was discharged 15 days later in good condition.

He remained well until May, 1952, when he re-entered the hospital with symptoms of an acute large bowel obstruction. There had been a severe emotional problem two days previous in relation to his work. A double-barrel transverse colostomy was performed and he was discharged with the colostomy functioning well.

In July, 1952, he was readmitted with a colocutaneous fistula. This was corrected, and the patient was discharged asymptomatic.

In November, 1952, he was admitted for colostomy closure and resection of the obstructing lesion in the lower left colon. At surgery the colostomy was taken down, and the remaining left colon and the distal loop of the transverse colon was resected, the transverse proximal loop being anastomosed to the sigmoid colon. Microscopically, this lesion again demonstrated thickening of the bowel wall with submucosal granulation and fibrosis and mucosal ulceration. In this specimen, many areas of polypoid hyperplasia of the mucosa were also noted. Several lymph nodes had follicular enlargement, small areas of granulation tissue, and heavy polymorphonuclear leukocytic infiltration. The patient has remained well and healthy to date, although he has the same job and continues to be very tense and nervous.

## Discussion

Regional (segmental) colitis is a nonspecific inflammatory lesion of unknown etiology involving one or more segments of the large intestine exclusive of the rectosigmoid or rectum. The third decade of life carries the peak incidence, and statistically there is no difference in incidence by sex. The lesions may be multiple or single and may involve the terminal ileum primarily or secondarily. Warren and Sommers[7] state that the inflammatory process is exudative and reparative in nature without granulomatous tendencies. Maschcowitz,[8] Wolf,[9] Bargen,[10] and Newman[11] all emphasize the granulomatous character of the lesions with ulceration of the mucous membrane and thickening of the bowel wall. The mesenteric lymph nodes are often enlarged with associated focal granulations. There is intense infiltration of the mucosa and submucosa with polymorphonuclear leukocytes, red blood cells, and old blood pigment. Microscopically, the process does not extend more than 6 cm. beyond the gross boundary of the lesion[11] and essentially normal bowel is found between multiple lesions, when they are present. It is felt by many that an etiological relationship with ulcerative colitis may exist. Bargen states that 4 to 10 per cent of patients with chronic ulcerative colitis observed at the Mayo Clinic also have segmental colitis.

Crohn[12] originally described the disease as "right-sided" colitis owing to the frequency of the right colon lesions under his observation. In more recent literature, Kellock[13] reports the splenic flexure as the more frequent site, and in Newman's[14] series of 201 cases there was no significant difference between the total number of left and right-sided lesions, although



FIG. 1. *(Case 1). Barium enema x-ray of colon showing constricting lesion of left colon.*

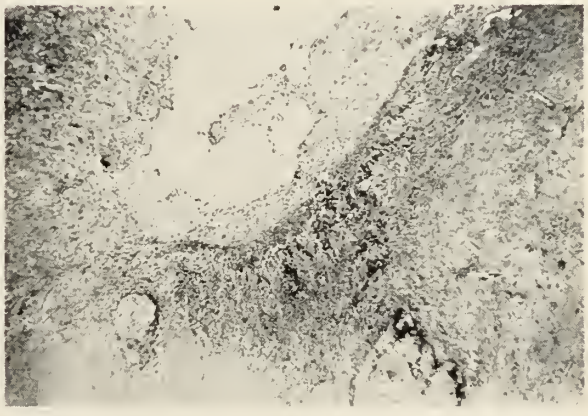


FIG. 2. *(Case 1). Section of resected colon showing base of ulcer extending through submucosa with extensive granulation tissue at base of ulcer. 100x H and E.*

he found a 12 per cent incidence of initial isolated lesions of the left colon. Segmental colitis may spread from the original site to other areas of the colon and to the terminal ileum. In 77 cases reported by Crohn, 40 per cent secondarily involved the ileum. Eighteen per cent of 140 cases reported by Barbosa et al.[15] and 22 per cent of 201 cases reported by Newman followed the pattern, although statistically there is a tendency for recurrences to spread toward, but not to involve, the rectum.

The mode of this spread is a point of controversy, but most investigators feel that it is by direct extension through the mucosa and submucosa. Garlock[16] presents the opinion that extension occurs by subserosal and mesenteric lymphatic vessels. Because of

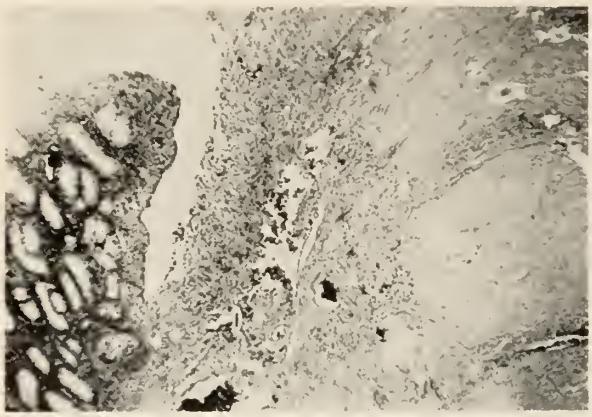


FIG. 3. *(Case 1). Margin of ulcer showing sharp separation of intact mucosa with undermined edges at base of ulcer.*



FIG. 4. *(Case 2). Barium enema x-ray of colon demonstrating constricting lesion of the splenic flexure.*

this, he recommends that with colostomy or with resection, the mesentery be sectioned to its base in order to interrupt all avenues of spread. When recurrences are seen or the disease is of long standing, the incidence of anorectal abscess or fistula is high,[10] as demonstrated in our second case, though the mucosa of the rectosigmoid and rectum is not involved.

## Treatment

The long term results with medical therapy have been disappointing. Recurrences with extension to the ileum or downward to the rectum with development of perianal or perirectal abscesses or fistulae, continued diarrhea, and malnutrition are all complications of nonsurgical management. Recurrence rate with medical therapy is over double that found with resection or short-circuit operations (Newman and Bargen[14]). Brooke states that 80 per cent of patients with segmental colitis will come to surgery and that "holding operations" are necessary to prevent anorectal fistulae, disabling diarrhea, and wasting due to steatorrhea. Resection of the lesion with primary end-to-end anastomosis is his choice of treatment. Bargen also favors resection, noting fewer recurrences than with short-circuiting procedures. Garlock[16] is of this same opinion and, in addition, makes a point of separation of the mesentery to its root to prevent spread.

An acute obstructive problem frequently arises with segmental colitis, often preceded by physical or emotional trauma. A complete diversion of fecal stream by double barrel colostomy is the operation of choice at this time, keeping in mind that future resection will probably be needed. If the colostomy cannot be placed far enough from the lesion to allow for future wide resection, a cecostomy or ileostomy is recommended. Again, Garlock[16] cautions that the mesentery must be severed to prevent spread of the disease to uninvolved bowel. Brooke[6] has stated that true obstruction does not exist with Crohn's disease, but obstructions are due to an amotile segment of bowel. He feels emergency operations with colostomy are



FIG. 5. *(Case 2). Section of resected lesion of splenic flexure of colon showing mucosal ulceration with thickening of submucosa and marked polymorphonuclear infiltration. 100X H and E.*

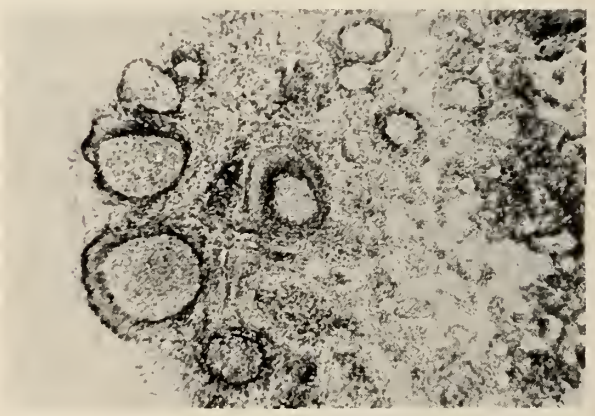


FIG. 6. *(Case 2). Section of mesenteric lymph node with edema and reticulum cell hyperplasia.*

not often necessary, but correction of fluid loss and chronic potassium deficiency will usually suffice, and definitive planned resection may be carried out at a later date. This is based on the premise of previous symptoms with chronic diarrhea, dehydration, malnutrition, and concomitant electrolyte depletion. Unfortunately, the acute obstructive problem is not always seen in the patient with previous disease, the onset often being sudden in an otherwise well person. In these instances, fluid and electrolyte correction is recommended as a preoperative preparation only, with complete diversion of the fecal stream by double barrel colostomy the immediate procedure of choice.

## Summary

Two cases of segmental colitis are presented. The first shows an acute onset and a clinical pattern similar to carcinoma of the colon. The second case presents some of the complications seen in the long term problem.

Surgical management is emphasized. Wide resection of the lesion followed by end-to-end anastomosis is recommended over short-circuiting procedures. The spread of the process to adjacent bowel via mesenteric lymphatics is discussed and the need for section of the mesentery to its base at the time of operation noted.

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RABIES EPIZOOTIC IN OHIO.— Following a record low in 1961 of 77 cases, of which only eight were canine, Ohio has experienced a tremendous epizootic of rabies during the current year. As of August 21 a total of 332 cases had been reported, 294 (89%) of these in wildlife species. 266 (91%) of the wildlife cases were skunks. During the second quarter (April, May, June) of 1962, Ohio had more reported rabies cases than any other state. In the past many authorities implied that dogs and other domestic animals were the actual reservoir of rabies that kept the disease going in wildlife. In county after county, investigations during 1962 have indicated that the problem of rabies control originates with the skunk.

It is true that rabies cases in wildlife does not lead to as many human exposures as a similar number of cases in domestic animals. The most immediate danger then is the spread of rabies from wildlife to domestic animals and thence to man and our present knowledge indicates this is happening. Of 15 cases of canine rabies reported this year investigations have shown that 14 of them have had definite or probable contacts with wildlife species. Fortunately there were only 10 human exposures to these 15 canine cases, which is certainly less than the usual amount of exposure to canine rabies. On the other hand there have been six cases of cat rabies that have been responsible for 19 human exposures, all of which required antirabies treatment. With the predominance of rabid wildlife being from rural areas, we must also assume that wildlife is the main source of infection for domestic farm animals. So far during 1962, twelve bovine and four horse rabies cases have been reported. As usual several farmers and veterinarians have been exposed at least indirectly to these cases by handling or examining them before it was suspected that they might have rabies.

It is imperative that better reporting of wildlife rabies cases must be obtained for a better understanding from an epidemiological standpoint and to properly decide where control efforts should be applied. Such information should be forwarded to the Veterinary Unit, Communicable Disease Division, Ohio Department of Health.— Division of Communicable Diseases, Ohio Department of Health: *Disease Control Information,* Vol. IV, No. 5, October 22, 1962.

# Bacteroides Septicemia And Osteomyelitis

## Report of a Case Complicating Sickle Cell Anemia

NORMAN STATMAN, M. D., and SHIMON SPITZER, M. D.

A GREATER awareness of the potential pathogenicity of anaerobic organisms, particularly of the genus *Bacteroides*, has developed as techniques for culturing anaerobic organisms have improved. Documented case reports of such infections appear with increased frequency in the literature.

The present case report is unusual in that it describes the occurrence of septicemia and widespread osteomyelitis due to *Bacteroides funduliformis* in a patient with sickle cell anemia.

### Case Report

A 19 year old unmarried Negro woman was first admitted to Cincinnati Jewish Hospital on December 16, 1960 because of fever accompanying complaints of pain in the epigastrium, back, and extremities. She had experienced similar recurrent painful episodes of 24 to 48 hour duration almost monthly since the age of 13 when the diagnosis of sickle cell anemia had first been established. These episodes had required hospitalization for transfusions on five occasions during this six year period.

*Family History:* The patient's family constellation consists of her mother, maternal grandmother, aunt, and six half siblings. Her father is unknown. There is neither history of anemia nor of any episodes that could be construed as sickle cell crisis in the other members of the family.

Physical examination showed an acutely ill, pale young woman of gracile habitus with a temperature of 99.6°F., pulse rate 100/min. and regular, respiratory rate 18/min., and blood pressure 110/60 mm. Hg. There was no icterus. The liver and spleen were not palpable and there was no significant adenopathy. Shoulders and knees were painfully tender bilaterally though there was no restriction of motion or objective evidence of arthritis.

*Laboratory Data:* Red blood cell count was 2,910,000/cu. mm.; hemoglobin, 6.9 Gm./100 ml.; hematocrit, 25 per cent; reticulocyte count, 10.5 per cent, and white blood cell count, 16,000/cu. mm. The differential count revealed polymorphonuclears 72 per cent, band cells 3 per cent, lymphocytes 15 per cent, monocytes 9 per cent and basophiles 1 per cent. Red cell staining revealed hypochromia with polychromatophilia, stippled and nucleated red blood cells, and several sickled red cells. Sodium metabisulfite sickle cell preparation was positive. The urine contained 2 to 3 red blood cells/HPF and 10 to 20 white blood cells per high power field. Urinary bilirubin was negative and urinary urobilinogen, 0.6 Ehrlich units/100 cc. Additional tests were reported as follows: serum bilirubin, direct 0.08 mg./100 ml., total 1.05 mg./100 ml.; serum iron, 60 mcg%; iron binding capacity, 324 mcg%; and iron saturation, 18 per cent. Hemoglobin electrophoresis showed 93.6 per cent hemoglobin S and 5.4 per cent hemoglobin F.

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Submitted January 3, 1962.

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The bone marrow revealed normal cellular elements with erythroid hyperplasia.

*Hospital Course:* Treatment included analgesics and transfusion of 1 unit of whole blood. She had spiking fevers of 102 to 103°F. for the first three days, then improved and was discharged on December 21, 1960, the sixth hospital day, having been afebrile for 48 hours. Her hemoglobin level was then 9.5 Gm./100 ml. and hematocrit 30 per cent. At discharge it was noted that a superficial ulceration, 4 cm. in diameter, had developed over the midportion of the right buttock.

### Second Admission

The patient was readmitted four days later on December 25, 1960, because of fever and pain as before. She was more acutely ill than previously with temperature 102.6°F., pulse rate 120/min., respiratory rate 32/min., blood pressure 120/75 mm. Hg. Scleral icterus was noted. A localized grade 2 systolic murmur was present. Bilateral costovertebral angle tenderness was elicited. The knees and shoulders were again tender without objective evidence of arthritis.

*Laboratory Data:* On admission the hemoglobin was 8.0 Gm./100 ml., hematocrit 24 per cent; on the second day, 6.5 Gm. and 22 per cent and on the third day, 5.3 Gm. and 19 per cent respectively. The white blood cell count was 14,600/cu. mm. with polymorphonuclears 53 per cent, band cells 25 per cent, lymphocytes 19 per cent, monocytes 3 per cent. Urinalysis showed 50 mg./100 ml. albumin and occasional red blood cells and white blood cells. Urinary urobilinogen was 2.1 Ehrlich units/100 cc; serum bilirubin, direct 2.1 mg., total 5.2 mg./100 ml., and fecal urobilinogen, 836 Ehrlich units/100 Gm.

*Hospital Course:* The patient ran a protracted septic course. On the tenth hospital day, she developed right upper quadrant pain, increasing tenderness and limitation of motion in the right shoulder and hips, and aching pain in both tibias. Abdominal examination showed only tenderness to pressure in the RUQ. Three blood cultures were drawn, and therapy was begun with chloramphenicol 0.5 Gm. orally every six hours. On the 13th hospital day, the patient was complaining bitterly of increasing abdominal tenderness and joint pain, mainly in the right shoulder and right hip but also in the left hip. For the first time, the liver was noted to have enlarged to 6 cm. below the right costal margin in the mid-clavicular line and to be markedly tender. Physical examination was otherwise unchanged. Repeated pelvic examination was normal and



FIG. 1. *Right shoulder, destructive process in the head and neck of the right humerus with pathological fracture. Narrowing of shoulder joint due to destruction of cartilage.*

mucoid cervical secretions showed only occasional gram-negative rods and rare gram-positive cocci. Cultures of this material revealed enterococci and anaerobic gram-negative rods which were not further identified.

X-rays of both hips and shoulders showed no abnormalities. An intravenous cholangiogram failed to visualize the biliary system, but subsequently, on the 69th hospital day, an oral cholecystogram was normal. Chest x-ray and intravenous pyelogram were normal. Fluoroscopy showed good motion of both leaves of the diaphragm. The cerebrospinal fluid was normal.

Three blood cultures drawn on the tenth hospital day were positive for *Bacteroides funduliformis*. On the 12th hospital day, a daily intravenous drip containing penicillin 30 million units and tetracycline 3.0 Gm. was started. Chloramphenicol was continued. The patient continued to spike fever to 104° and 105°F. rectally in the afternoons and evenings while being virtually afebrile in the mornings until the 19th hospital day, when she suddenly became afebrile. On the 20th hospital day, penicillin and chloramphenicol were discontinued, and treatment was maintained with tetracycline alone. The patient noticed marked subjective improvement in joint complaints and right upper quadrant tenderness. By the 23rd hospital day, the liver had receded to 3 cm. below the right costal margin. The ulceration on the buttock had healed.

She continued to be afebrile until the 28th hospital day when spiking fever to 101°F. was again noted. Repeated blood cultures were negative. She complained again of increasing pain in the right shoulder and left hip. X-rays of the shoulders and hips taken on the 40th hospital day revealed marked narrowing of the joint space of the left hip joint and evidence of osteomyelitis of the superior portion of the left femur. The right shoulder showed irregular partial confluent radiolucencies in the head of the right humerus and a pathological fracture in the neck of the right humerus (Fig. 1). *Bacteroides funduliformis* was found in the 0.25 ml. of straw-colored fluid, which was aspirated from the left hip. In view of these findings 2.4 million units or procaine penicillin intramuscularly and 600 mg. penicillin V orally every four hours were added to the regimen. The lower extremities were placed in continuous traction. On this therapy the patient became afebrile on the 54th hospital day and has been essentially afebrile since. She was kept in traction for approximately three weeks. On the 69th hospital day, roentgenographic evaluation revealed persistent irregular radiolucencies and a pathological fracture of the right humerus. Films of the hips revealed no marked change of the left femur but the appearance of osteomyelitis in the proximal end of the right femur together with questionable osteomyelitis of the distal end of the right femur.

The antibiotics were continued in the same dosage until the 92nd hospital day, when the tetracycline and the parenteral penicillin were stopped. Only the oral penicillin was continued. Roentgenograms on the 94th hospital day showed extension of the osteomyelitis of both hips and the entire pelvis (Fig. 2). The right shoulder revealed evidence of healing (Fig. 3).

The most recent survey on the 114th hospital day showed no extension of the disease process of the hips and pelvis but probable development of osteomyelitis in the distal femurs and proximal tibias.

The patient remained afebrile, was feeling well, had a good appetite, and was gaining weight when discharged on the 118th hospital day. Physical examination at that time showed normal vital signs and moderate limitation of motion of both shoulders and hips. The liver was still palpable 3 cm. below the right costal margin. Heart and lungs were not remarkable. She was discharged receiving penicillin V, 2.5 Gm. per day in divided doses.

*Summary:* A 19 year old Negro woman with sickle cell anemia was hospitalized because of fever, bone pain and arthralgia. *Bacteroides funduliformis* septicemia and resultant widespread osteomyelitis developed. Tetracycline, though regarded the antibiotic of choice against Bacteroides infections, proved only partially effective in this patient's treatment. Addition of penicillin to the therapeutic regimen seemed to be of distinct clinical benefit.

## DISCUSSION

### Bacteriology:

Many Bacteroides infections presumably escape accurate diagnosis because of the inability of many bacteriology laboratories to do accurate anaerobic studies and because of unfamiliarity with the organisms on the part of many clinicians. Actually, the pathogenicity of Bacteroides was demonstrated as early as 1898 by Jean Halle.[1] A tentative diagnosis of Bacteroides infection may be made by the isolation of gram-negative, non-sporulating, anaerobic, pleomorphic or non-pleomorphic organisms.[2]

The organisms isolated on the tenth hospital day from the blood and on the 44th hospital day from the aspirate of the left hip appeared to be identical and showed the following features: The organisms were extremely small, pinpoint sized rods with rounded ends. On prolonged cultivation, these rods developed



FIG. 2. *(Oblique position.) Widespread destructive process in bony structures and associated narrowing of hip joints due to articular destruction.*



FIG. 3. *Right shoulder, healing phase of the destructive process and pathological fracture. Note periosteal elevation.*

into large swollen, sausage-shaped rods and ultimately into large, spherical bodies. The organisms proved to be anaerobic and gram-negative with bipolar staining. Growth in Brewer's thioglycollate was abundant and in this medium, the swollen forms and spheroids prevailed. The morphology of the organisms, the anaerobic nature, the cultural and biochemical characteristics place this organism in the family of BACTEROIDACEAE, genus SPHAEROPHORUS, species FUNDULIFORMIS.

Sensitivity pattern with discs on a rabbit blood brain-heart infusion agar plate incubated for four days at 37°C anaerobically:

The organism proved to be **sensitive** to: aureomycin; chloramphenicol; tetracycline; erythromycin, and **resistant** to: penicillin; novobiocin; neomycin; streptomycin; bacitracin; kanamycin; polymyxin B sulfate.

Sensitivity pattern with tube dilution method performed in tubes with 5 ml. Brewer's thioglycollate and read after 24 hours incubation at 37°C.

*Penicillin:* beginning inhibition: 12.05 Units/ml.
complete inhibition: 25.0 Units/ml.

*Tetracycline:* beginning inhibition: 0.2mcg/ml.
complete inhibition: 0.4mcg/ml.

## Pathophysiology:

Bacteroides organisms may be present as saprophytic inhabitants of many mucosal surfaces such as the pharynx, respiratory tract, gastroenteric tract, urinary tract and female genital tract.

Most clinical infections are due either to the pleomorphic, more invasive, *Bacteroides funduliformis* or to the non-pleomorphic, less invasive, *Bacteroides fragilis*. The infections begin as a suppurative lesion in one of the tissues where the organisms exist physiologically. The organisms proliferate and give rise to local thrombophlebitis from which infected emboli may dislodge, cause septicemia and distant metastatic abscesses -- most commonly in the lungs, liver, joints, kidneys and brain,[1,3] in order of decreasing incidence. As expected from the distribution of the organisms, the common portals of entry include tonsillar and peritonsillar abscesses, otitis media and mastoiditis, bronchopneumonia and empyema, appendicitis and other gastroenteric foci, purulent endometritis and urinary tract infections.[4]

The first reported case of Bacteroides osteomyelitis was by Chandler and Breaks[5] in 1941 in a 12 year old boy who developed osteomyelitis of the right hip with sequestration of the head of the femur due to *Bacteroides funduliformis* following otitis media and mastoiditis. The incidence of osteomyelitis as a complication of Bacteroides septicemia has not been determined. In an analysis based on the review of the literature, Smith and Ropes[6] found the incidence of joint metastases to be high in Bacteroides septicemia. The joints involved in their series were the large joints, including elbow, shoulder, knee and hip joints. The smaller articulations were spared. A case of Bacteroides septicemia complicated by widespread osteomyelitis has to our knowledge not been reported. Of interest is the localization of the osteomyelitis. Similar to the Bacteroides arthritides which involve chiefly the large joints, the osteomyelitis in our patient involves bones adjacent to the large joints. Because of the roentgenographic evidence of osteomyelitis and the lack of definitive arthritis in our patient, we believe that the purulent material aspirated from the joint was secondary to the osteomyelitis rather than a metastatic abscess in the joint primarily.

In our patient, in spite of intensive investigation, the portal of entry remained undetermined. However, the development of right upper quadrant pain, an enlarging tender liver and increase in the degree of hyperbilirubinemia were interpreted as presumptive, though not definitive, evidence for the presence of hepatic abscesses. McVay and Sprunt[4] have stressed the frequent occurrence of jaundice and hepatic abscesses in situations where the portal of entry has been the gastrointestinal tract. Five out of six cases of Bacteroides septicemia originating from the gastrointestinal tract had liver abscesses demonstrated at the time of autopsy or surgical intervention. Definite evidence of septicemia with osteomyelitis and joint infection as well was corroborated by the blood cultures, the bony radiographic changes, and the cultures of the aspirate from the left hip joint.

## Clinical Features:

Of clinical interest in this patient was the fact that the symptomatology of the septicemia mimicked that of sickle cell crisis without septicemia, e. g. fever, arthralgia, increased jaundice, and bone pain. It was only the persistence of such symptoms beyond the duration noted in her previous episodes, coupled with the subsequent course, that led to the correct diagnosis.

Bacteroides infections have been reported to com-

plicate debilitating disorders, especially intestinal malignant tumors.[7] Similarly, patients with many types of debilitating diseases are unusually susceptible to Salmonella infections. Perhaps both situations reflect increased susceptibility to infection by gram-negative intestinal bacteria. The predisposition of children with sickle cell disease to osteomyelitis has been reported by Hughes and Carroll[8] who noted nine cases of osteomyelitis in patients with sickle cell disease. Four cases were due to *Salmonella,* two to hemolytic *Staphylococcus aureus* and in three cases, the organism was not identified. In our patient, similar to the patients with Salmonella osteomyelitis, there occurred multiple bony involvement and destruction severe enough to be associated with pathological fractures.

Therapy:

Bacteroides septicemia was regarded as a uniformly fatal disease until 1941. At that time, Brown et al.,[9] reported one of the first cases to recover from septicemia due to Bacteroides with treatment consisting of high doses of sulfapyridine and blood transfusions. With the onset of the antibiotic era, many drugs were tested for effectiveness in Bacteroides infections. In vitro sensitivity studies done by McVay and Sprunt,[4] Fingold and Hewitt[10] suggested that tetracycline was by far the most effective agent. Chloramphenicol, erythromycin, and, to a lesser extent, penicillin were also thought to be effective in many Bacteroides infections, judging from these in vitro results.

In considering the response of our patient to the given antibiotics, it has to be pointed out that her initial response was to a combination of penicillin and tetracycline, both in high doses. The patient was afebrile eight days after penicillin was stopped and started to spike fever on the 28th hospital day in spite of maintenance levels of 3 Gm. of tetracycline daily. Only after reinstituting penicillin on the 40th hospital day did she become afebrile and remain afebrile. The cessation of tetracycline therapy on the 92nd hospital day, while penicillin was continued, did not seem to change the patient's course.

The in vitro sensitivity tests performed on the organism cultured from the blood and from the material obtained from the left hip showed that the organism is very sensitive to tetracycline but practically resistant to penicillin. We accept the conclusions drawn in other reports that tetracycline is an effective drug in the treatment of Bacteroides infections as evident from the in vitro sensitivities and the objective response to this drug. From the single case presented, however, we would like to postulate that there are cases of Bacteroides infections and septicemias where penicillin in high doses plays a decisive roll in counteracting further progression of the disease. Although the in vitro sensitivities might show relative resistance of the organism to penicillin, it may be worthwhile to add penicillin to the treatment of Bacteroides septicemia and its complication. Such a discrepancy between the in vitro sensitivity to penicillin and the clinical response can be explained by some inadequacy in the in vitro test, by a synergistic action between penicillin and tetracycline, or by delivering a high enough concentration of penicillin to the lesion to be effective.

## Summary

A case of Bacteroides septicemia with widespread osteomyelitis complicating sickle cell disease is reported in detail. No previous such cases are known to the authors.

It is important to note that the symptomatology from the septicemia and osteomyelitis may be similar to that seen in sickle cell anemia in crisis.

Salmonella is considered the most likely organism to be the cause of osteomyelitis in sickle cell disease. However, the possibility of Bacteroides or other anaerobic organisms should not be overlooked.

The unusual response of this patient to penicillin warrants giving this drug further consideration in the treatment of Bacteroides septicemia and osteomyelitis.

Acknowledgment: We are indebted to Dr. Gordon Margolin and Dr. Morton Hamburger for their critical review of the manuscript; to Dr. Lee Rosenberg for his review and interpretation of the roentgenograms; and to Miss Elly Hubregtse for the bacteriological identification and sensitivity studies.

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STRESS.—"My heart needs no special protection against the stress of modern living. If Americans become timorous about stress, they could fall prey to a hardy and less timorous nation. It is up to us to accept life's challenges."—Irvine H. Page, M. D., Cleveland: in *The New Physician,* Vol. 11, No. 11, November, 1962.

# Non-Beta Islet Cell Carcinoma Of the Pancreas

## A Case Report of Zollinger-Ellison Syndrome Treated By Implantation of Iridium[192]

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THE description of a syndrome by Zollinger and Ellison in 1955 has contributed additional information concerning the pathogenesis of chronic peptic ulceration. The failure of adequate conventional medical or surgical therapy to remedy such a problem demands that attention be directed to this syndrome. Although most of their criteria have been reaffirmed in the subsequent medical literature, it is significant from a therapeutic approach that an exception to the usual observation has been recorded.[15] The experimental role of the exocrine pancreatic secretions in the pathogenesis of peptic ulceration was reported in 1932.[12,13] Since the report of Zollinger and Ellison, additional eccentric manifestations of pancreatic tumors have been reported. These will be referred to in this report.

There is unanimity of opinion that a surgical approach to therapy is the most effective when feasible. The present report records an instance wherein the surgical approach was directed to the pancreas. When the lesion was found inoperable, radioactive iridium[192] was introduced into the tumor. This study also indicated that the disease may manifest a phasic character, and, in the literature reviewed, suggestions are aroused indicating the influence of immunologic inhibition of gastric hyperchlorhydria and limitations placed on peptic ulceration.

### Case Report

The patient was a 65 year old white man who was submitted to an exploratory laparotomy for unexplained gastrointestinal hemorrhage and who died four weeks later from postoperative complications.

Ten years prior to the onset of the last illness, he had experienced symptoms confined to the upper digestive tract manifested by epigastric fullness and discomfort associated with upper abdominal bloating and pyrosis. The intensity of the symptoms varied from mild to moderate. Frequently, specific food idiosyncrasies seemed to provoke attacks, but more often than not dietary indiscretion was not provocative. In 1955, six years prior to the last illness, he experienced an episode of epigastric pain with radiation through to the back and associated with nausea and vomiting. The duration of his illness lasted several hours and required no analgesics. Relief was spontaneous.

In 1957, two years later, this symptom complex recurred, and on this occasion it was associated with hematemesis and tarry stools. When first examined his hemoglobin level was recorded as 8 Gm./100 ml. He was treated conservatively with whole blood transfusions, and bleeding did not recur.

In 1958, one year later, he developed a severe episode with epigastric pain radiating through to the back associated with a febrile course of four days duration. Although pancreatitis was suspected, serial serum amylase studies were never found to be elevated, and the suspicion was not confirmed. Three weeks after this illness, exploratory laparotomy revealed a large mass in the body and tail of the pancreas with metastasis to lymph nodes in the base of the mesentery. The liver was free of gross disease. There was no evidence of gastric or duodenal ulcer. The lymph nodes at the base of the mesentery were biopsied. Microscopic examination of the biopsy material was reported as "schirrous adenocarcinoma of the pancreas."

In view of the presumed inoperability of the lesion, the operating surgeon referred the patient to Memorial Center in New York City, for surgical consultation. At that institution, another exploratory laparotomy was performed in August of 1958, and the tumor was again found to be not resectable. Iridium[192] was implanted within the tumor through 15 needles. The strength of each seed was recorded as 0.7 mg. radium equivalence, and the total dose was 6 mg. radium equivalence. Biopsy of the pancreas at this time was interpreted as positive for carcinoma, possibly the islet cell type.

Following therapy, he continued to experience mild upper digestive symptoms with intervals of exacerbations. Two years postoperatively, the symptoms assumed major proportions for one week with epigastric fullness and nausea and vomiting, but they subsided spontaneously. While on a fishing trip six months later (two and a half years postoperatively) he developed an acute, transient episode of delirium, confusion, and irrational behavior. The delirium followed shortly after eating a well balanced breakfast and lasted for one hour. He was examined by a physician, who reported to the patient's son-in-law that he recorded a systolic blood pressure of over 200. The presumptive impression was that the patient was suffering from an alteration in cerebral hemodynamics without motor disorder.

Three months later he was examined because of sudden onset of copious tarry diarrhea. Four days later, after whole blood transfusions and stabilization of his hemodynamics, a laparotomy was performed. Examination of the stomach, pylorus, and duodenum failed to reveal the source of bleeding. The organs were opened and examined through ade-

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quate exposure. The tissues in the vicinity of the pancreas were bound down by massive adhesions. The head of the pancreas was described as indurated. A biopsy specimen was removed from the area and tissue drains were inserted into the left subphrenic space. Microscopic sections of the biopsy tissue were interpreted as "compatible with adenoma of the pancreatic islet tissue, low grade malignant change not excluded."

The postoperative course was complicated by the occurrence of a pyloric fistula and subphrenic abscess. Prior to the fistula formation, the measured 24 hour gastric secretion was productive of up to 4,000 cc. of gastric juice. Late in the course, a feeding jejunostomy with replacement of the fistular fluid did not avert the starvation effects or the severe electrolyte deficiencies manifested by hypokalemia, hypocalcemia, and hypoproteinemia. The patient died four weeks after surgery. Table 1 contains the significant radiologic and laboratory studies prior to his last illness.

## Autopsy

The significant autopsy findings were localized to the abdominal cavity. The head and neck were excluded from examination. Abstracts from the autopsy protocol revealed the following:

*Peritoneal Cavity:* There was no free fluid in the abdomen. There were numerous fine and dense fibrotic adhesions but no evidence of bowel obstruction. A fistulous tract led from the surgically induced scar opening into the pylorus through a 15 mm. defect. There was a subdiaphragmatic abscess over the left lobe of the liver communicating by a long tract to the area of the pyloric fistula.

*Pancreas:* The whole organ was difficult to identify. The head did not appear abnormal, but the body and tail were contracted and distorted. Section revealed diffuse fibrosis with diffuse tumor formation and discrete nodular masses of apparently encapsulated tumor varying from 10 to 35 mm. in diameter. In addition, the pancreas contained the previously implanted metal cylinders. There was tumor infiltration into the adjacent tissue around the celiac artery and the retroperitoneal tissues.

Microscopically, the tumor was composed of "small fairly uniform cells that have enlarged, dark, and irregular nuclei. In most areas there is extensive dense hyalinized fibrosis, and the tumor is in the form of round cell nests but also often separated into cords by the development of the fibrosis."

*Gastrointestinal Tract:* The esophagus was normal. The stomach was edematous and contained "two irregular ulcerations in the posterior wall of the fundus; one approximately 15 mm. and the other 20 mm. in diameter." Grossly, the ulcers were said to reveal "thin walled submucosal vessels probably veins which were patent and exposed by ulceration and apparently formed the bleeding site." The duodenum, jejunum, and ileum were free from ulceration. Microscopic examination revealed the ulcer to be submucosal with no evidence of malignancy.

*Liver:* Many tumor nodules were found scattered throughout the substance of the liver. The nodules were described as varying up to 30 mm. in diameter and as being firm and fibrotic in appearance. Microscopic examination, in addition to extensive fatty metamorphosis and acute degenerative changes, the liver contained "numerous foci of metastatic tumor; composed of small cells with round and oval nuclei of fairly uniform size; the tumor cell nests are surrounded by well developed thin fibrotic septa. In the larger metastases, there is an extensive central hyalinized fibrosis of the tumor."

## Discussion

The physiologic consequences resulting from the presence of functioning non-beta, islet cell tumors of the pancreas, are, for the most part, confined to the gastrointestinal tract. Significant dimensions of a syndrome were described by Zollinger and Ellison[1] when they reported on their studies and reviewed the literature. They established that there was "peptic ulceration in unusual locations, or recurrent stomal ulcers following any type of gastric surgery short of total gastrectomy; gastric hypersecretion of gigantic proportions persisting despite adequate conventional medical or surgical therapy." Extracts from the serum of one patient contained an abnormal protein, which possessed electrophoretic properties identical to glucagon, and which demonstrated hyperglycemic properties suggesting it was similar to glucagon produced by the alpha cells of the pancreas.

Although earlier reports originating in England attributed ulcerogenic properties to gluagon, more recent reports[6,11] have concluded that glucagon suppresses gastric secretion in normal subjects and in patients with duodenal ulcers. Additional studies disclose the isolation of a substance from primary and secondary nonspecific islet cell carcinomas, which is gastrin-like in its substance.[7,9] Gastrin, the hormone released from antral mucosa, has not been fully purified nor has its structural character been defined. The methods used to demonstrate its gastric acid stimulating activity are indirect, utilizing conscious dogs prepared with denervated gastric pouches. The results, reported by Marks,[7] Grossman,[8] and Gregory,[9] disclosed that the extracts prepared from these adenomas served as an extremely potent gastric acid secreting stimulant.

Table 1

| | | |
|---|---|---|
| 1951 | Gallbladder series | Normal |
| | Upper G. I. Series | Diverticulum of duodenum |
| 1952 | Upper G. I. Series | Same |
| | Barium enema | Negative |
| 1955 | Serum Amylase | 77 mg./100 ml. |
| | Gallbladder series | Normal |
| | Barium enema | Normal |
| | Upper G. I. Series | Coarse mucosal folds Hypertrophic gastritis |
| 1957 | Upper G. I. Series | Questionable posterior bulbar ulcer |
| 1958 | Upper G. I. Series | Hypertrophic gastritis |
| | Serum amylase | 28 mg./100 ml. |
| | Hemoglobin | 8 Gm./100 ml. |
| | Hematocrit | 25 Vol. % |
| | Serum calcium | 4.8 mEq/L |
| | Phosphorus | 2.6 mEq/L |
| 1961 | Upper G. I. Series (Hampton technique) | No disease found |

Hallenback, et al.[10] have also reported gastrin-like activity from extracts of an islet cell carcinoma. This report also includes gastrin-like activity extracted from a benign islet cell adenoma, from an adenocarcinoma of the bile ducts (although no peptic ulceration nor diarrhea was present in the patient), and also from a pancreas free from tumor obtained from a patient who had presented with the Zollinger-Ellison syndrome. It would seem apparent that a variety of lesions in the pancreas might provoke a common pathophysiological sequel. However, from a review of this literature, the impression is gained that considerable latitude exists in the pathologic interpretation of pancreatic lesions. The presence of a structurally normal pancreas associated with the Zollinger-Ellison syndrome had never been reported.

A closely related observation, however, was re-

corded by Mathews and Dragstedt[12] in 1932. They were able to produce duodenal ulceration in conscious dogs by the experimental diversion of pancreatic juice from the duodenum, but ulceration rarely followed total pancreatectomy.[13] Similar duodenal ulcers and hyperchlorhydria can be created in the dog by diverting the biliary flow from the duodenum into the ileum.

Other gastrointestinal consequences associated with the Zollinger-Ellison syndrome have been diarrhea and steatorrhea. Although this was not included as an essential component of the syndrome, it was recorded as a prominent feature in about one third of the patients. Intestinal studies using radioactive triolein have demonstrated no defect in small bowel absorption of fat. Temporary alleviation of diarrhea has been reported by Haubrich, et al.[5] when gastric secretions are removed from the stomach, or when temporarily diverted, totally neutralized, and re-introduced into the gastrointestinal tract. Neither vagotomy nor external x-ray irradiation of 1500 r to the acid bearing parts of the stomach has proved to be palliative.[1,2]

The occurrence of diarrhea and steatorrhea and the islet cell tumors without associated peptic ulceration has been the subject of numerous reports.[3,4,5,14] Diarrhea, hypokalemia, and nephropathy have been described as a syndrome[3] associated with similar islet cell tumors of the pancreas, but this, in essence, represents advanced stages of dehydration and electrolyte dysequilibrium, with the nephropathy not unlike that evoked by advanced hypokalemia.

However, others[14] suggest that these tumors may be responsible for two distinct syndromes: one, peptic ulceration; another, a diarrhea and steatorrhea syndrome, in which peptic ulceration may never appear or many years may elapse before it develops. They also accentuate the lack of aid from histological studies of all the tumors so far reported. The common denominator in most reports, is that the islet cell tumors arise from non-beta cell types. Emphasis may be attributed to this theory by the report of Rawson, et al.,[15] who report a 15 month cure in a patient with the diarrhea syndrome preceding the peptic ulceration by eight years. The cure followed removal of the tumor without resort to total gastrectomy.

The diverse responses of the gasrtointestinal tract to the presence of these pancreatic tumors have been studied, until recently, only from an anatomic and pharmacologic standpoint. The fact that biologic inhibition of gastrin could be demonstrated in animal experiments[16] might stimulate a new avenue of approach to the study of so-called functioning and non-functioning tumors. Such a study might also account for the periods of exacerbations and apparent remissions of the disease and serve to explain why the duration of the disease may vary from 3 months to 30 years.[2] The recurrence of symptoms in the present report spanned a period of 10 years.

Tumor study reveals lesion grows and metastasizes slowly. Distant metastases, although rare, have been reported,[2] but metastases are local and to the liver. The usual mode of death reported has been the result of postoperative complications.

## Summary

A case study is reported of a 65 year old white man with a non-beta, islet cell carcinoma of the pancreas. His illness spanned a period of 10 years, punctuated with exacerbations and remissions of a peptic ulcer-like syndrome. Although repeated radiologic studies failed to disclose the presence of peptic ulceration, he seemed to improve in remissions. On two occasions there was upper gastrointestinal hemorrhage of major proportions. Thirty-two months prior to his terminal illness, the inoperable islet cell carcinoma of the pancreas was treated with implanted iridium$^{192}$, containing 6 milligrams equivalence of radium delivering 22,400 r at a rate of 1000 r per hour. He died of postoperative complications after exploratory laparotomy for gastric hemorrhage. A source for the bleeding was not found at surgery. Autopsy, 26 days after surgery, revealed two small gastric ulcers in the posterior wall of the fundus of the stomach and the islet cell carcinoma with extensive local metastases and widespread metastases to the liver.

A review of the literature pertinent to the clinical features of the disease has been attempted.

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# The Clinical Evaluation of the Heart

## IV. Further Observations on the Second Heart Sound

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CORRECT appraisal of acute right heart overload is one of the most difficult, yet most important, diagnoses in clinical medicine. It is a fact that today massive pulmonary embolism is successfully treated by prompt surgical removal of the clot. The problems of differential diagnosis are known to all and any clue that may lead to a proper course of action cannot be overlooked. I have recently observed a massive pulmonary embolus that was accompanied by wide, fixed splitting of the second sound. This occurred without change in the electrocardiogram. The diagnosis was confirmed at necropsy, since the patient died while being prepared for open heart embolectomy. A recent report has also noted a wide fixed split of the second sound in the pulmonary edema of high altitude, a physiological state due to pulmonary venule spasm, which results in acute right heart overload. These observations are fragmentary, but they emphasize that sudden appearance of an abnormally wide split may be of crucial importance in diagnosis.

Splitting of the second sound may also be widened by intraventricular conduction delays or early closure of the aortic valve. When $A^2$ is early, as in mitral insufficiency or simple ventricular septal defect, the second sound may fail to close in expiration. The early closure of $A^2$ is thought to be due to the rapid emptying of the left ventricle. Abnormal splitting of the second sound is frequently observed in these conditions, but it is less useful diagnostically than are other clinical parameters.

Right bundle branch block is a benign entity commonly associated with a delayed $P^2$ and a wide split. Recently I saw a young man whose physical examination suggested trivial aortic stenosis. He had a slightly accentuated left ventricular impulse and an aortic ejection murmur, which clearly waxed on expiration. What made no sense was the fact that his second sound was broadly split in both phases of respiration. The paradox of mild aortic stenosis and a wide split was resolved by examination of the patient's electrocardiogram. It showed right bundle branch block, which had developed during cardiac catheterization. This procedure, in turn, had revealed a small pressure gradient across the patient's aortic valve.

### Intensity of the Second Sound

The classical notions concerning variations of intensity of the second heart sound are well known. $A^2$ is accentuated in systemic hypertension and any condition in which the aorta is dilated and brought closer to the chest wall. It is diminished in valvular aortic stenosis. $P^2$, normally softer than $A^2$, is increased when there is pulmonary hypertension and decreased in the presence of pulmonary stenosis. Less well known is the fact that $A^2$ is usually well heard in pure aortic insufficiency. Doctors have frequently asked why a loud $A^2$ can be heard in aortic insufficiency when the valve "doesn't close." The fact is, the sounds of semilunar valve closure come more from sudden tensing of the valve cusps than they do from approximation of the cusps against one another. I've seen specimens of rigid, calcified, aortic valves that couldn't possibly have closed, and yet gave a "closure" sound during life that must have been due to tensing each time ventricular pressure fell below aortic.

The occurrence of a normal or loud $A^2$ in the presence of clinical aortic stenosis should make one immediately suspicious of outflow obstruction at other than valvular level. This is particularly true in the older patient. Functional obstruction from muscular hypertrophy of the left ventricular outflow tract accounts for about 5 per cent of all cases of aortic stenosis. Its clinical recognition, to be discussed at another time, can save needless and dangerous surgical exploration.

One final word of caution concerning interpretation of "loudness" of heart sounds. $P^2$ is generally a soft sound and, as we know, is accentuated by pulmonary hypertension. In thin chested youngsters and in some normal adults, however, $P^2$ seems prodigiously loud when pulmonary artery pressure is perfectly normal. Doctor and patient may be spared considerable anxiety if this fact is kept in mind before pulmonary hypertension is diagnosed.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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# A Clinicopathological Conference

## From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT P. CARSON, M. D., *President*

### *Presented by*

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PRESENTATION OF CASE

THIS 68 year old white woman entered University Hospital with the chief complaint of abdominal pain of four months' duration. One year prior to admission, when she was a patient of the surgical clinic, she had a nonvisualizing gallbladder. With the onset of the pain in the right upper quadrant, she became jaundiced and was hospitalized elsewhere. She was treated with intravenous fluids and nasogastric suction, and the jaundice subsided spontaneously. She did well until three weeks prior to admission to University Hospital, when she again developed nausea, vomiting, chills, fever, and constant severe right upper quadrant pain. The patient had lost 30 pounds since the onset of her illness. She had been taking no medicine. She had no known allergies. Her past history revealed that she had had a vaginal hysterectomy seven years prior to admission.

### Physical Examination

The patient was a thin, anemic-looking white woman who was not jaundiced. Her temperature was 101°F., her blood pressure 110/50, her pulse rate 80 per minute, and her respiratory rate 20 per minute. The positive physical findings included a grade 3 systolic murmur at the apex of the heart and a hard, irregular, tender liver which extended 4 cm. below the right costal margin.

### Laboratory Data

The van den Bergh was 0.1 mg. per 100 ml. direct and 0.6 mg. total; cephalin flocculation reaction was 2 plus; the thymol turbidity 50 mg./100 ml.; the alkaline phosphatase was 45.3 units; the serum amylase 24 units; the total protein was 7.4 per cent, albumin 3.8 and globulin 3.6 per cent; the blood cholesterol 110 mg./100 ml. with 67 per cent esters; the bromsulphalein test showed 74 per cent retention. The fasting blood sugar was 97 mg./100 ml. The white blood cell count was 32,989; hemoglobin 7.1 Gm./100 ml.; hematocrit was 22 per cent; prothrombin time 61 per cent. The blood urea nitrogen was 14 mg./100 ml. Leucine aminopeptidase was 2200 units; SGOT 31 units, SGPT 9 units; lactic dehydrogenase was 575 units.

The electrocardiogram taken the day after admission was within normal limits. Chest x-rays showed slight underaeration of the left lung base probably due to impaired diaphragmatic motility. Flat and upright abdominal films showed findings consistent with a paralytic ileus.

### Hospital Course

For the first 10 days following admission the patient spiked daily temperatures to 101°. A combination of penicillin, streptomycin and Chloromycetin® did not affect this temperature. Blood cultures were negative.

Upper gastrointestinal studies done on the third hospital day showed a collection of contrast material in a pocket on the anterolateral aspect of the descending duodenum. Distal to this collection there was incomplete filling of the duodenum with distortion of the mucosal pattern. The C-loop was not expanded. Intravenous cholangiogram done on the foliowing day showed faint visualization of the biliary radicles, which appeared dilated, and there was strong suggestion of a radiolucent calculus in the ditsal common duct.

The patient was treated with whole blood transfusion until her hemoglobin stabilized at 12.5 Gm. Despite antibiotics she continued to spike daily temperatures as high as 105°. During the first week her white blood cell count gradually dropped from 32,000 on admission to 10,000. Her alkaline phosphatase dropped from 45 units on admission to 29 units. On her eighth hospital day she was noted to be slightly icteric. Alkaline phosphatase rose to 50 units, and direct and total bilirubin were 0.6 and

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1.0 mg. respectively. The patient continued to have nausea and vomiting, and surgical consultation was obtained on her ninth hospital day.

On her tenth hospital day an exploratory laparotomy was done. Postoperatively her temperature dropped to normal and remained normal for five days. On her fifth postoperative night she complained of left chest and arm pain and broke out in a cold sweat. Electrocardiogram at that time was normal. Direct and total van den Bergh, drawn the day before, were 10.9 and 14.4 mg. respectively. She began to spike daily fevers.

The chest x-ray taken on her ninth postoperative day showed right pleural effusion and pneumonitic infiltrates in the left upper lobe and probably in the right upper lobe. Abdominal films on the same day showed a paralytic ileus and a left upper quadrant mass. On that day the blood urea nitrogen was 33 mg.; white blood cell count 38,250; hemoglobin 10.0 Gm.; hematocrit 34 per cent; serum sodium was 113 mEq., potassium 4.2 mEq., chlorides 95 mEq., and $CO_2$ combining power 23 mEq./L.; direct van den Bergh 7.8 mg. and total 11.3 mg. One blood culture was negative.

The patient was treated with IPPB aerosols, Chloromycetin, penicillin, streptomycin and oxygen. She continued to do poorly. A repeat chest film on her seventeenth postoperative day showed a massive right pleural effusion. A chest tube was inserted but only 150 cc. of bile-colored fluid was obtained. A culture of the pleural fluid grew out *E. coli* and *Proteus*. The patient's condition gradually deteriorated. She died quietly, despite supportive measures, on the morning of her eighteenth postoperative day.

## CLINICAL DISCUSSION

DR. ELLIOTT: The subject of our discussion today was a 68 year old white woman who complained of abdominal pain of four months' duration. The pain apparently was not steady throughout the four months, as it apparently "recurred" about three weeks prior to her admission. However, I would guess that it was the same kind of abdominal pain she had felt four months ago. Her nonvisualizing gallbladder demonstrated one year ago indicates the presence of biliary disease, provided the test was done in the correct manner and, provided that she had not had diarrhea and that she was not jaundiced and had no liver disease which would interfere with the concentration of the dye in the gallbladder.

### Prolonged Remission

Her present illness which began four months prior to admission when she was hospitalized elsewhere once again points to biliary disease, and with these two strong indications I think we can assume that she did have it. She was treated and she apparently became completely well and remained so until three weeks prior to admission, when she developed a recurrence of the same illness. The fact that she was apparently well in between suggests that she did not have a lesion such as cancer, which would have progressed during the interval of four months. This is a little too long a period for jaundice to subside and a patient to feel well and still harbor a growing cancer of the stomach, pancreas or biliary tree. However, she did have something which remained abnormal and caused her to return the second time with similar complaints pointing to persistent biliary disease.

The past history of a vaginal hysterectomy does not help us very much. It solely suggests that she could have some adhesions in her abdomen or some kind of inflammatory process which probably did not have much influence on her upper abdominal disease. She was thin and anemic with a low hemoglobin, and she had a fever. The systolic murmur at the apex of the heart may have been related to her anemia or may indicate a more serious cardiovascular disease but had nothing to do with her abdominal pains.

### Hepatomegaly and Biliary Obstruction

The most important finding of course was that she had a hard, irregular, tender and enlarged liver. This, together with fever, jaundice and good evidence of biliary disease in the past, would make us believe that she definitely was suffering from some type of biliary tract infection. Her slightly elevated van den Bergh, her cephalin flocculation and thymol turbidity test could be indicative of a nonspecific kind of inflammatory disease of the liver, either primary or secondary to biliary obstruction which we cannot tell at this moment. Her markedly elevated alkaline phosphatase in the absence of jaundice would strongly suggest to me that she does have some partial obstruction of her biliary tree with infection or rather extensive metastatic disease with segmental obstruction of the hepatic radicles. So, although I felt earlier that her history did not sound much like cancer with metastasis, I must confess that her laboratory data may well suggest this or some other type of biliary obstruction.

Her low amylase is not significant, while her elevated globulin seems consistent with a chronic, slowly progressive disease. Her fasting blood sugar was mildly elevated, but I am suspicious that the blood might have been taken while she had intravenous fluids immediately after admission. Her low cholesterol speaks against biliary obstruction, while her BSP retention is fairly definite evidence of serious hepatic impairment. Retentions of this extent are of course seen in very advanced metastatic disease of the liver or in marked parenchymatous degeneration. The latter seems to be ruled out by her other tests and the absence of jaundice.

I would then summarize that her laboratory tests so far still suggest chronic infection with some obstruction of the biliary tract and enlargement of the liver. Her white blood cell count of 32,000 certainly suggests a fairly marked degree of sepsis, and her

anemia may be due to a mild but persistent infection. Chronic anemia and mild elevations of globulin are seen in long-standing abscesses produced experimentally in this manner and are seen also in patients with long-standing bacteremia and bacterial infection. Her prothrombin time does not suggest serious parenchymal liver involvement but is rather consistent with a moderate degree of biliary obstruction. Her leucine aminopeptidase was rather markedly elevated, which can be regarded as indicative of pancreatic parenchymal damage, hepatic damage or biliary obstruction. I cannot interpret her high lactic dehydrogenase. Chest x-rays showed some underaeration of the left lung base, which is surprising in view of the fact that physically we are pointing to the liver and the right base as the real source of her trouble.

### Primary Biliary, Secondary Pancreatic Disease

I think we have a woman with some primary biliary disease, and the fact that she showed up now with findings in the left side of the abdomen would suggest that she had a secondary pancreatitis. The other pertinent finding is of course the appearance of a new lesion in the duodenum which certainly must be related to the present chronic illness. This may well represent a new growth or tumor of the duodenum. An alternative possibility would be that it represents a collection of barium in a gallbladder which has perforated into the duodenum. The question is, does this tumor arise primarily in the duodenum or in adjacent structures? Certainly a tumor arising in the head of the pancreas or the distal common bile duct would be far more common, particularly in the presence of long-standing biliary disease.

She was treated with antibiotics without much response, indicating indeed that there was some persisting perforation at the bottom of her trouble. Despite antibiotics her course was one of continuing sepsis. Her alkaline phosphatase fluctuated a little, and with the progress of the disease she was noted to be icteric. Finally it became evident that she was not going to be cured by antibiotics and an exploratory laparotomy was done. We are not told what was found, but the operation seems to have produced some improvement. However, on the fifth day something happened and the patient once again resumed her downhill course. In view of the elevated alkaline phosphatase, I am inclined to believe that they found a tumor or a fistula of the biliary tree.

The pain she developed in her shoulder and arm on her fifth day suggests some type of diaphragmatic irritation due to leaking of juices into her abdomen. Conformation might have been obtained by serum amylase determination or paracentesis, neither of which has been mentioned. From then on, her course once more became that of sepsis. Abdominal films again showed paralytic ileus and a possible left upper quadrant mass suggesting there was some leaked fluid accumulating under the left diaphragm as well as the right. The appearance of infiltrates in her upper and lower chest suggests either localized fluid or pulmonary emboli. In any case, no surgical drainage or re-exploration was carried out. Perhaps the attending staff thought she was too sick or else she did not need it. They should have been able to tell — from a serum amylase or from a peritoneal tap — what was leaking, but something was leaking into her abdomen and she continued to go downhill and died.

The primary lesion could still be the lesion that caused this extravasation, or her secondary difficulty in her abdomen in the late postoperative period may have been a breakdown of whatever was actually done at surgery. Some effort was made to tap the chest fluid, which was bile-colored. This could be extremely significant if we knew how jaundiced the patient was at the time. If the fluid in her chest definitely contained more bile than the blood serum, then it represents evidence of some secondary penetration of fluid through the diaphragm into her chest. If on the other hand, the fluid was not more jaundiced than her serum, it would simply indicate a pleural effusion secondary to some irritation of the diaphragm. I wish I knew the cause of the leak around this woman's duodenum. It would explain the partial biliary obstruction and would tell us whether she had hepatic metastasis to elevate her alkaline phosphatase. Personally, I am inclined to consider a malignant tumor as the most likely lesion. I think it could be also a fistulization through an inflamed gallblader or a gallbladder involved by tumor, but I am inclined to place this as a second diagnosis because of the absence of any air in the biliary tree.

### General Clinical Discussion

DR. ROGER WILLIAMS: What do you think her total course was?

DR. ELLIOTT: I think the total course was one of sepsis and was related directly to a loculated lesion in the gastrointestinal tract. As a preoperative diagnosis I would place a primary tumor of the distal biliary system as the first diagnosis, although either the gallbladder or pancreas may also be a strong possibility.

DR. WILLIAMS: How do you explain the fluctuation of her alkaline phosphatase during her hospital course?

DR. ELLIOTT: I interpret this as a mild fluctuation under the influence of antibiotics indicating a temporary decrease in the inflammatory process surrounding the primary lesion.

DR. WILLIAMS: Dr. Dunbar, can you tell from the film whether the mass in the chest is in the lungs or whether this is an empyema?

DR. J. D. DUNBAR: This major mass which we see is pleural fluid and is pretty atypical for a pneumonitis.

DR. ELLIOTT: The idea that this was a primary

abdominal lesion with secondary pleural effusion is based largely on the character of this fluid, containing bile and *E. coli* and *Proteus*.

DR. J. V. WARREN: My rule of thumb is that if it looks on the film as though you have a lot of fluid and then you try to tap it and you get only a little, this is much more in favor of an inflammatory lesion. In cardiac failure the opposite is more likely to be true.

DR. WILLIAMS: Dr. Coltman, how would you explain this sort of anemia in the face of the patient's fever and bacteremia?

DR. C. A. COLTMAN: I am not sure that this patient's anemia was due to chronic infection. She had evidence of a gastrointestinal lesion, and I would not be surprised if her anemia was hypochromic, and I think in a postmenopausal woman with hypochromic anemia we should always think of bleeding from the G. I. tract until proven otherwise.

### CLINICAL DIAGNOSIS

1. Carcinoma involving biliary tract, gallbladder or pancreas with perforation and septicemia.
2. Biliary obstruction with jaundice.

### PATHOLOGIC DIAGNOSIS

1. Carcinoma of the gallbladder with cholangitis and liver abscess.
2. Empyema and pulmonary abscess in right chest.

### PATHOLOGIC DISCUSSION

DR. VON HAAM: At the time of surgery two biopsies were received, one from the tumor and the other supposedly from the gallbladder. The tumor was located just beneath the liver and microscopically showed a well-differentiated squamous cell carcinoma. The biopsy taken from the gallbladder region showed only fibromuscular tissue without any epithelial elements. For this reason our surgical pathologist expressed himself in favor of carcinoma of the pancreas in spite of the fact that the surgical impression at the time of operation was that of carcinoma of the gallbladder.

At the time of autopsy we found the right pleural cavity filled with 300 cc. of thick greenish-brown foul-smelling material. There was also a recent pericarditis. The right lung showed an abscess in the upper lobe containing similar greenish-brown pus. Another abscess was found in the liver just beneath the diaphragm, and a communication existed between this abscess and the empyema of the right chest. The peritoneal cavity was free of any exudate and showed only recent adhesions at the surgical site.

Beneath the liver a large tumor mass was found which completely replaced the gallbladder, filled the hepatic ligament, infiltrated the liver tissue, the head of the pancreas and the wall of the duodenum. The tumor was of grapefruit size and showed a considerable degree of necrosis and central softening. In the center of the tumor mass a small cholesterol stone was found. The biliary tree seemed to open into the tumor mass. The head of the pancreas was invaded but not replaced by the tumor. The wall of the duodenum and colon were also invaded by the tumor. Although the tumor infiltrated the liver it did not metastasize to the liver nor did it metastasize to the mesenteric lymph nodes. The remainder of the autopsy showed no noteworthy changes.

The microscopic examination of the organs showed an acute suppurative process in the lung tissue and on the pleural surface of the right lung. The pericarditis was of the acute fibrinous type. The tumor was mostly of the squamous cell type, but in some sections taken from the hepatoduodenal ligament and the pancreas a mixed adenosquamous cell type of carcinoma was found. The entire tumor was heavily infiltrated with acute inflammatory cells and showed extensive necrosis. Sections through the pancreas revealed no outstanding disease with the exception of areas involved by the tumor. The pancreatic ducts appeared normal. No normal mucosa of the gallbladder could be identified. The mucosa of the duodenum overlying the neoplastic infiltrate showed atypical glandular proliferation compatible with a carcinoma in situ.

In our interpretation of the origin of the tumor we feel that the tumor could have arisen from the gallbladder, the biliary tree or the head of the pancreas. A possible origin from the duodenum or the colon seems less likely in spite of the fact that carcinoma in situ was found in the duodenum. The location of the tumor, its mode of spread, and the lack of metastasis to lymph nodes or liver suggest the gallbladder as the most likely origin. The presence of a gallstone in the center of the tumor lends additional support to this interpretation. The death of the patient was unquestionably due to the spreading infection which probably originated in the biliary tree, causing a cholangitic liver abscess with perforation into the pleural cavity.

### General Discussion

DR. C. R. MACPHERSON: In spite of the clinical evidence suggesting a hospital-acquired infection, I feel that this represents a preëxisting infection and therefore does not constitute a hospital-acquired infection but is an extension of the underlying process.

DR. WILLIAMS: The fact that jaundice entered the clinical picture rather late also favors a tumor of the gallbladder rather than a tumor of the pancreas or the lower ends of the biliary ducts. In both latter instances jaundice usually appears much earlier.

DR. VON HAAM: I think this point is well taken. As you know, we always regard a gallstone as a possible factor leading to cancer of the gallbladder and for this reason we recommend removal of gallstones even though they are symptomless.

# Maternal Mortality Report For Ohio—1959*

By the OSMA COMMITTEE ON MATERNAL HEALTH

WITH a real sense of pride, your Committee on Maternal Health presents herewith, the fifth annual report. This document is published in compliance with a House of Delegates directive adopted April 23, 1953, creating the Committee on Maternal Health, and follow-up action taken by The Council on January 16, 1941.[1]

The report consists of four sections, the first briefly covering activities of the Committee since its last report to The Council on September 17, 1961. The progress on various projects in which the Committee participates is described. The second portion is a summary of selected statistics taken from the Ohio Maternal Mortality Study for 1959, covering 88 counties. In the third section, the statistics are briefly analyzed to provide information on various trends; the last part contains recommendations presented by the Committee based on experience gained from the Maternal Mortality Study.

## Activities

No changes have appeared in the Committee personnel during the past year. Twenty members, representing the 11 Councilor Districts of Ohio, still comprise the Committee. General practice, obstetrics, gynecology, cardiology, pathology and anesthesiology are represented in the practice of these physicians. An over-abundance of meetings and commitments complicated the calendars of both Committee members and the OSMA headquarters staff. As a result the Committee on Maternal Health met only twice this year. Presently the Committee plans to schedule a regular meeting in every "quarter" of the year in order to complete its work.

Each month in this column, "Maternal Health in Ohio," the Committee has published selected case reports from the Maternal Mortality Study, on an anonymous basis; instructive comments by the Committee and an anonymous consultant, are provided in each case. In the September, 1962, issue of *The Journal,* the "Maternal Health in Ohio" column[2] completed *six* years of continuous publication on a monthly basis. Due to a progressive lack of space in *The Journal,* hereafter this column will appear quarterly, in the issues of March, June, September and December.

With the approval of The Council and the Committee, assistance and selected data from the Ohio Maternal Mortality Study were provided for two research projects. The first investigated the effects of pregnancy on congenital heart disease. The second incorporated cases involving ruptured uterus with a survey of similar cases, in an Ohio hospital prior to 1955.

## Projects

With the approval of The Council several additions were made to "Guiding Principles for Obstetric Care."[3] These revisions not only bring the document up to date but also augment the latitude of standards employed in the evaluation of maternity care available, during the study of maternal death cases.

Obstetric code sheets are complete on all *maternal cases* in our files through 1959; the cases have had data transcribed onto IBM cards. This project facilitates the location of material for use in specific educational programs (see below).

The subcommittee acting in an advisory capacity to a special Maternity Hospital Licensure Committee, Ohio Department of Health, continues to function.

Part I, of a course on first aid management, "Emergencies of Pregnancy and Childbirth," is completed with a film-strip and accompanying brochure. This training course, designed specifically for use in the instruction of cadets and officers of the Ohio State Highway Patrol, has met with magnetic acceptance; requests have been made to use it elsewhere, with permission.

Through efforts of our Committee members, an exhibit ("Maternal Health in Ohio") was displayed in the scientific section of the Annual Meeting, Ohio State Medical Association, May 14-18, 1962, in Columbus. Specific results gleaned from the Maternal Mortality Study in Ohio were portrayed.

A project in cooperation with the Ohio Association of Anesthesiologists is currently under way. Primary objective of the study is to recommend the

*A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Since the work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical reports.

definition of a "Prescribed Course" for obstetric anesthesia, specifically designed for registered nurses in Ohio.

The Committee held a demonstration as a panel, "Maternal Mortality Conference" for the Annual Meeting, Ohio Academy of General Practice, October 19, 1962, in Columbus.

Selected statistics from the Study for the year 1959 are published below in compliance with directives of The Council. They are arranged in a style of uniformity to facilitate comparison with similar reports published previously. Terminology and nomenclature employed in the Study, adopted after careful deliberation, follow closely those prescribed in the International Classification,[4] to provide uniformity.

### Ohio Maternal Mortality Study
### Statistics for 1959

| | | |
|---|---|---|
| **Total live births in Ohio, 1959** | | 232,578 |
| Total cases studied | 102 | |
| Case studied, cause of death undetermined | 1 | |
| Cases not studied due to lack of information | 0 | |
| Cases not studied due to lack of investigation and return | 6 | |
| **Maternal Deaths** (classified) | 80 | |
| White | 58 | |
| Non-white | 22 | |
| Age: | | |
| Teens | 8 | |
| 20's | 31 | |
| 30's | 37 | |
| 40's | 4 | |
| Parity: | | |
| Primigravidae | 9 | |
| Multiparae | 60 | |
| Unknown | 11 | |
| Place of death: | | |
| Hospital | 74 | |
| Home | 6 | |
| Other | 0 | |
| Method of Delivery: | | |
| Operative | 38 | |
| Nonoperative (spontaneous) | 29 | |
| Not delivered | 13 | |
| Route of Delivery: | | |
| Vaginal | 53 | |
| Cesarean | 16 | |
| (antemortem) | 13 | |
| (postmortem deliv.) | 3 | |
| Laparotomy (ectopic preg.) | 1 | |
| Not delivered | 10 | |
| Case classification: (when death occurred) | | |
| Group I (fr. concept. to 20th wk.) | 6 | |
| Group II (fr. 20th wk. up to 28th wk.) | 0 | |
| Group III (fr. 28th wk. through term) | 9 | |
| Group IV (postabortal, postpartum) | 65 | |
| Autopsies | 60 | |
| (Included 16 coroners' cases) | | |
| Prenatal care (apparent from data sheets) | | |
| Adequate | 37 | |
| Inadequate | 17 | |
| None | 5 | |
| Excluded (ectopic preg. and abortion) | 12 | |
| Unknown or not reported | 9 | |
| Classification of preventability: | | |
| Nonpreventable | 22 | |
| Preventable (avoidable factor) | 58 | |
| Patient Responsibility ($P_1$) | 17 | |
| Personnel Responsibility ($P_2$) | 33 | |
| Both $P_1$ and $P_2$ | 7 | |
| $P_1$, $P_2$ and $P_3$ | 1 | |

### Classification of Primary Causes of Death:

| | | |
|---|---|---|
| **Hemorrhage** | | 21 |
| Abortion, without sepsis | 2 | |
| Abruptio | 0 | |
| Afibrinogenemia | 1 | |
| Abruptio | 1 | |
| Am. fl. embolus | 0 | |
| Dead fetus | 0 | |
| Ruptured uterus | 0 | |
| Atony, uterine, postpartum | 2 | |
| Ectopic pregnancy without sepsis | 3 | |
| Laceration, extrauterine | 2 | |
| Placenta Praevia | 1 | |
| Retained Placenta | 1 | |
| Ruptured uterus (no afibrinogenemia) | 8 | |
| Other | 1 | |
| **Infection** | | 16 |
| Abortion, alleged "criminal" | 8 | |
| Abortion, septic, spontaneous | 2 | |
| Tuberculosis | 1 | |
| Up. Resp. Inf. | 0 | |
| Other: | | |
| Peritonitis | 3 | |
| Septicemia (puerperal sepsis) | 1 | |
| Septicemia (other) | 1 | |
| **Toxemia** | | 4 |
| Acute yellow atrophy | 1 | |
| Hypertension, chronic (incl. hypertension with cerebrovascular hem.) | 0 | |
| Eclampsia | 2 | |
| Preeclampsia | 1 | |
| Renal disease | 0 | |
| **Other** | | 39 |
| Amniotic fl. emb. (no hem.) | 2 | |
| Anesthesia | 11 | |
| (general) | 7 | |
| (regional) | 4 | |
| Aspiration, Pneumonitis (not directly from anesthetic) | 0 | |
| Cardiac arrest (not specified) | 0 | |
| Cardiac disease | 7 | |
| Cerebrovascular hemorrhage (no tox.) | 2 | |
| Chorioepithelioma | 2 | |
| Diabetes | 0 | |
| Dyscrasia, blood, other | 0 | |
| Intestinal obstruction | 1 | |
| Lower nephron nephrosis | 1 | |
| Pulmonary edema | 0 | |
| Pulmonary embolus | 9 | |
| Renal disease, chronic, unspecified | 3 | |
| Shock, trauma (incl. Ac. Puerperal Inversion, Uterus) | 0 | |
| Uremia, acute | 1 | |

In Ohio, there were 232,578 live births reported during 1959. From this maternal mortality study, the Committee classified 80 *maternal* deaths for the year. The maternal mortality rate was 0.38 per 1,000 live births, or 3.86 per 10,000 live births for 1959.

## Discussion

The significance of these statistics is slightly more impressive, since there were 1,462 fewer live births in 1959 than in 1958.

Every case was studied thoroughly by the Committee, evaluating all *available* facts on an anonymous basis, then classifying each one as to preventability, listing avoidable factors. "Guiding Principles for Obstetric Care"[3] was the standard "yardstick" employed constantly for classification.

Out of 102 cases studied for 1959, 80 (78.4 per cent) were voted *maternal deaths*, while 21 were voted *non-maternal deaths* (no connection with the pregnant or puerperal state); the cause of death in one case was *undetermined*. Although the total number of cases varies somewhat from the 1958 report,[5] it is reasonable to assume that some cases throughout the state escaped inclusion in the Study, due to error in diagnosis, or failure to include "pregnancy" on the cause of death, as certified.

Again, multiparae led the parity group (60 of the 69 reported), leaving 11 cases unknown (parity not reported). As to place of death, 74 patients died in hospitals, while only six died at home.

Fifty-three patients (66.2 per cent) died following vaginal delivery; there were 16 cesarean sections (13 antemortem, 3 postmortem), while 13 patients died undelivered. One ectopic pregnancy died after laparotomy, while the other two ectopic gestations were not operated. Sixty patients (74.9 per cent) had autopsies performed; 16 of these were coroners' cases.

Of the 80 maternal deaths 62.6 per cent of the eli-

gible group apparently had *adequate* prenatal care; 12 cases were excluded (ectopic pregnancy and abortion) while nine were not recorded.

From data available, 58 of the 80 maternal deaths were voted *preventable* (avoidable); in one unclassified case the cause of death was not determined after complete autopsy and a thorough chemical investigation.

A summary of the primary cause of death in the 80 cases (Fig. 1) proves most interesting.

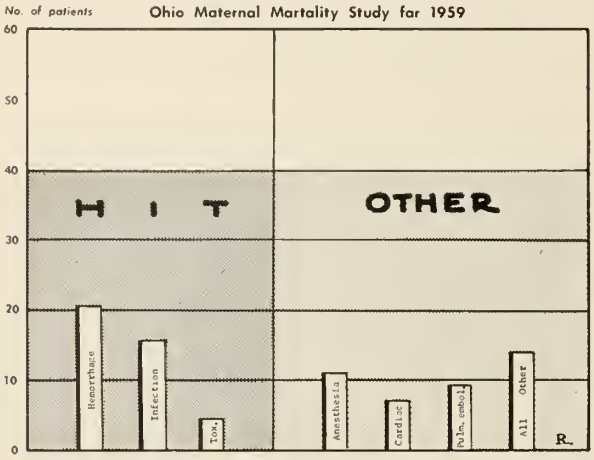



Fig. 1. Classification of primary causes of death, 80 maternal deaths for 1959

Hemorrhage (from all major and subordinate causes) again leads the list as a single primary cause of death, with 21 cases (26.3 per cent); this figure includes *eight* cases of ruptured uterus! Deaths due to hemorrhage show an increase of five over 1958.[5] There were eight cases of alleged "criminal" abortion in which the patients died of sepsis compared to six in 1958. Deaths from toxemia *descended* to an "all time low" with only *four* during 1959!

Surprising is the recurrence of a rise in deaths from *anesthesia* to *eleven*, the highest since 14 were classified in the annual report for 1955. Pulmonary embolism (not from amniotic fluid) still leads the remainder of "Other Causes of Death" with *nine* cases; next in order of occurrence, is cardiac disease with *seven* of the 39 cases in this miscellaneous category. One case with cause of death "undetermined" (mentioned above), was classed neither as maternal nor non-maternal.

## Recommendations

1. Once more the Committee recommends that the Ohio Maternal Mortality Study with its research and educational features be continued with vigor to reduce further the maternal mortality and morbidity in Ohio. It is desired to point out that systematically arranged annual statistical reports such as this one for 1959 are vital in establishing trends related to maternal deaths, viz., hemorrhage, anesthesia, etc. Educational material may then be directed towards their improvement.

2. Council members have done well to convey interest and support of this project to members of their respective districts. Continuation of their efforts in this direction is recommended, of course.

3. Since *hemorrhage* leads the list of primary causes of maternal deaths, and since *anesthetic* deaths have increased in this 1959 report, it is recommended that efforts be increased to improve specific education along preventive lines, at all levels.

4. It is further recommended that efforts be increased to establish and maintain studies of *all* maternal deaths in *local* communities. Through these studies, all personnel dealing directly with the pregnant patient may be apprised currently of facts leading to improved management of the pregnant women.

The Chairman desires to acknowledge with appreciation the faithful devotion of Committee members who have conscientiously discharged their duties over the past year. On behalf of the Committee, the Chairman acknowledges with gratitude the assistance offered by attending physicians, representatives of various County Medical Societies, the Ohio Department of Health, and numerous other agencies and individuals. Without their efforts and untiring cooperation, this Maternal Mortality Study could not have been completed.

Respectfully submitted,

ANTHONY RUPPERSBERG, Jr., M. D., *Chairman*
*Committee on Maternal Health*

Approved by The Council of the Ohio State Medical Association, September 23, 1962.

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LACTATION SUPPRESSION.— Bendroflumethiazide, 5 mg. twice a day for five days, was successful in each of 40 consecutive patients who needed to have lactation suppressed. It had definite advantages over synthetic estrogen for this purpose: no patient experienced the distressing breast engorgement so common in the first 24 hours after receiving synthetic estrogens, and it did not interfere with the lochia or with the subsequent involution of the uterus. The only disadvantage of bendroflumethiazide was a large diuresis.— ABSTRACT: Maurice Healy (London): *Lancet*, I:1353-1354, June 17, 1961.




# NEWS AND Organization Section

# Proceedings of The Council

## Action Taken on Various Committee Reports and Plans Made for Future Association Programs and Activities

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the Columbus office on Sunday, November 11, 1962. Those in attendance were: All members of The Council (except Dr. Robert E. Howard, Cincinnati, Councilor of the First District); Dr. Paul F. Orr, Perrysburg, delegate to the AMA; Dr. P. John Robechek, Cleveland, and Dr. T. L. Light, Dayton, alternate-delegates to the AMA; Mr. Wayne E. Stichter, OSMA legal counsel; Mr. Frank W. Van Holte, Columbus, assistant treasurer of Ohio Medical Indemnity, Inc.; and Messrs. Nelson, Saville, Page, Edgar, Moore and Traphagan, members of the OSMA administrative staff.

### Minutes Approved

Minutes of the meetings of The Council held on September 22-23, 1962 were officially approved.

### Reports by Councilors

Reports were made by the individual Councilors on activities within the Councilor Districts.

### OSMA Payment-in-Full Insurance Plan

Dr. Hamwi and Mr. Nelson reported that the suggested, tentative payment-in-full insurance plan of the OSMA was now under consideration by the various specialty groups and the Ohio Academy of General Practice, all of which had been requested to send in comments or suggested changes by January 1, 1963. Communications to these groups and a letter which went to county society presidents, advising them of this procedure, were read and discussed. No action was taken by The Council, inasmuch as final action on formulating a plan to be presented to the OSMA membership as a whole will not be taken until various groups, which now have the plan under consideration, submit reports.

### Amendments Approved

By official action amendments adopted by the following county medical societies to their constitutions and bylaws were approved:

Belmont County — Amendments adopted by the Belmont County Medical Society on September 20.

Lorain County — Amendments adopted by the Lorain County Medical Society on October 9.

Summit County — Amendments adopted by the Summit County Medical Society on October 2.

### Proposed Amendments to OSMA Constitution and Bylaws

Mr. Stichter was authorized by The Council to prepare suggested amendments to the Constitution and Bylaws of the Ohio State Medical Association which, if approved by The Council, would be submitted to the House of Delegates in May of 1963. The subjects to be covered are as follows: An amendment to Chapter 11, Section 1, which, if adopt-

ed, would make it possible for a component county medical society to grant a special type of membership to an osteopath and an amendment which would make the president-elect and the past-president ex officio members of all committees.

### Committee Reports Approved

By official action the reports of the following committees were approved:

**Judicial and Professional Relations Committee,** based on meetings of that committee held on October 6 and 7, 1962.

**Committee on Workmen's Compensation,** based on a meeting of that committee held on October 6, 1962.

**Committee on Laboratory Medicine,** based on a meeting of that committee held on October 14, 1962.

**Committee on Maternal Health,** based on a meeting of that committee held on October 14, 1962.

**Joint Committee on General (Family) Practice,** based on a meeting of that committee held on October 10, 1962.

**Committee on Radiation,** based on a meeting of that committee held on November 4, 1962.

**Ohio Cancer Coordinating Committee, Inc.,** based on a meeting of that committee held on October 28, 1962.

**Joint Advisory Committee on Athletic Injuries,** based on a meeting of that committee held on October 30, 1962.

The report of the **Committee on Rural Health was officially approved,** except those portions which dealt with a change in the rural medical scholarship and with respect to inviting the AMA to hold its Annual Congress on Rural Health in Columbus in 1964. Action on these items was deferred, pending more discussion by the committee and more investigation by The Council.

**Note: News articles pertaining to activities of the various committees are published from time to time in *The Ohio State Medical Journal*.**

### Report on November 6 Elections

Mr. Saville presented a detailed report on the results of the recent November 6 elections and there was a general discussion.

### Activities of AMPAC Reviewed

The activities of AMPAC were reviewed and discussed. It was decided that Ohio should continue on the same basis in its relationship with AMPAC.

Correspondence from AMPAC with respect to meetings in Los Angeles at the time of the interim session of the AMA was discussed. By action of The Council, it was decided that Dr. Hamwi, Dr. Tschantz and Mr. Page should attend the evening dinner session on November 25 and that Dr. Tschantz and Mr. Page should attend the breakfast planning conference on November 26.

### Appointment of Special Committee on the Keogh Law

Following a general discussion of the provisions of the recently enacted Keogh Law, the President was authorized to appoint a special committee to inquire into the feasibility of a plan by the Ohio State Medical Association whereby members could take advantage of the Keogh Law. Pursuant to this action, Dr. Hamwi appointed the following committee: Dr. Hardymon, chairman, Dr. Petznick, Dr. Light, and Mr. Stichter.

### AMA Meeting in Los Angeles

Plans for activities of the Ohio delegates at the coming Los Angeles AMA meeting were reviewed.

### 1963 Annual Meeting

Mr. Page reviewed the activities, to date, of the Committee on Scientific Work with respect to the program for the 1963 Annual Meeting, which will be held at the Sheraton-Cleveland Hotel the week of May 12.

The following recommendations with respect to the program on the morning of Tuesday, May 14, **were approved:** "The Hopeless Case" by Dr. Frank J. Ayd, Jr., Baltimore, Maryland; "Tax Planning for Physicians" by Mr. Bernard D. Hirsch, Director, Law Department, American Medical Association, Chicago; "What's New in Washington?" by Aubrey D. Gates, Director of Field Service, American Medical Association, Chicago; "Status of the OSMA Payment-in-full Medical Surgical Insurance Plan" by Dr. George J. Hamwi, Columbus.

### Report on AMA Mental Health Congress

Mr. Edgar presented a report on the AMA Mental Health Congress held recently in Chicago. He pointed out that recommendations made by the Ohio group which attended the congress would be reviewed by the Committee on Mental Hygiene of the OSMA and that definite recommendations, if any, would be presented later to The Council.

### Policy on Waiver of Dues for 1963

The following policy with respect to annual dues for 1963 **was adopted:**

A. That dues for new members in practice, affiliating with the OSMA during the last six months of the calendar year 1963, namely, July 1 to December 31, inclusive, shall be $17.50, one-half the regular per capita dues of $35.00. The pro-rating of dues shall not apply to former members reaffiliating.

B. That the following procedures shall apply during 1963 with respect to OSMA annual dues of members on extended active duty in the military service or in the United States Public Health Service:

1. State Association dues for 1963 shall be

waived for members on extended active duty in the military service or U. S. Public Health Service.

2. State Association dues for 1963 shall be waived for physicians who were members of the Association in 1962 and who enter such services during the calendar year 1963 before the payment of 1963 dues.

3. A refund of membership dues will not be made if a member enters such services in 1963 after his 1963 dues are received at the Columbus office of the Association.

4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions.

C. Annual Ohio State Medical Association dues for 1963 for a physician serving in an internship or residency program approved by the AMA Council on Medical Education and Hospitals who meets the membership eligibility requirements of the OSMA and who is accepted into membership by a component medical society shall be $7.50. Such intern or resident shall be entitled to receive *The Ohio State Medical Journal* as part of his membership privileges.

### 1963 Conference of County Society Officers

There was a discussion with respect to the program for the March 3 Conference of County Society Officers and Committeemen. It was agreed that the following subjects should be covered: "The Growing Emphasis on Religion and Medicine"; "How Auxiliaries Can Aid in County Society Projects"; "Medicine's Stake in Federal Legislation"; "The Ohio General Assembly and You"; "The OSMA Payment-in-Full Insurance Program"; "Legal Do's and Don't's for County Medical Societies."

### Report on Polio Vaccine Situation in Ohio

Mr. Page reported on the polio vaccine situation in Ohio as of this date. His report contained the following recommendation:

Sabin oral polio vaccine programs are proposed, planned, under way, or have been completed in all except three Ohio counties, according to information from our newspaper clipping service and from the Ohio Department of Health. Of the three counties without Sabin programs, two are continuing with their existing Salk immunization projects.

Seventy-eight of the 85 Sabin oral polio vaccine programs in Ohio counties are sponsored or are co-sponsored by county medical societies according to specific information now in our files.

There being no further business, The Council adjourned to meet on Saturday afternoon, December 15, starting at 2 o'clock and on Sunday morning, December 16, starting at 9:30 o'clock.

## Postgraduate Courses Offered At Ohio State University

Ohio State University College of Medicine has announced a number of postgraduate courses to be offered, the list beginning in January 1963 and running to October. So that physicians may make arrangements in advance, the following list is printed. Additional information may be obtained by contacting Dr. John A. Prior, Director of the Center for Postgraduate Medical Education, 1645 Neil Avenue, Columbus 10, Ohio.

A Day in Psychiatry, January 14.

Electromyography I, January 24, 25, 26.

Practical Management of Infectious Diseases, February 6.

What's New in Emergency Management of Chest Injuries and in Thoracic Surgery, February 13.

Recent Advances in Obstetrics and Gynecology For General Practitioners, February 20.

Sixth Annual Ophthalmology Course, March 4, 5.

Symposium on Allergy, March 20.

Pediatric Progress in 1963, April 3, 4, 5.

Psychiatry Seminar — Manfred S. Guttmacher, M D., April 5.

Hemodynamic Effects of Anesthesia, April 12, 13.

Alumni Day, April 20.

Pediatric Advances for General Practice (Invitational Seminar), April.

Office Orthopedics for the Family Physician, May 2.

Psychiatry Seminar — Jacob Arlow, M. D., May 31.

Environmental Physiology (Preventive Medicine), June 10 - 14.

International Conference on Renal Hypertension, July 12, 13.

Aerospace Medicine, September 8 - 14.

Recent Progress in Gastrointestinal Surgery, September 27, 28.

Management of Cerebral Vascular Diseases in the Aged, October 9.

Ophthalmic Pathology, October 17, 18, 19.

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The Southwestern Ohio Society of General Physicians in collaboration with the University of Cincinnati College of Medicine is sponsoring a seminar on "Medical Disorders of the Kidneys and Lower Urinary Tract," on December 2.

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G. Mennen Williams, assistant secretary of state for African affairs, praised the services of Dr. Robert A. Hingson, Cleveland, for his part in vaccinating some 250,000 Liberians against smallpox. This project was reported in a recent issue of *The Bulletin* of the Academy of Medicine of Cleveland.

# Annual Roundup on Federal, State and Local Taxes for Physicians

AS ANOTHER YEAR approaches most Ohio physicians will again face the task of filing returns and making payments under several categories of Federal, State and local tax laws. The information presented in this article is offered for the purpose of furnishing at least basic information on the following categories of taxes and placing emphasis on those points of particular interest to physicians:

(1) Federal Income Tax, including payroll withholding on employees' salaries.

(2) Federal Social Security Tax including Old Age, Survivors' and Disability Insurance tax and the Federal and State Unemployment Insurance taxes.

(3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash and accounts receivable.

(4) Ohio Workmen's Compensation tax, required of those with three or more employees (optional for those with one or two), and the Disabled Workmen's Relief Fund tax.

(5) Ohio Sales and Use Tax.

(6) Municipal Payroll Tax, applying to residents of cities or villages which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

## FEDERAL INCOME TAX

Taxpayers will pay 1962 Federal Income Taxes under provisions of the Revenue Code of 1954, subject to provisions of the Revenue Act of 1962 and certain other measures of tax importance passed by the Congress. Among other things, the 1962 Revenue Act introduced a new tax credit of 7 per cent of qualifying investment in business property and equipment.

### Forms and Payments

Every person under 65 years old whose gross income for the year was $600 or more, and every person 65 years old or older whose gross income was $1,200 or more, must file certain income tax returns with the District Director of Internal Revenue for his district not later than April 15, 1963.

There are two types of returns, Form 1040A, and Form 1040.

Form 1040A may be used if the income was less than $10,000 and consisted entirely of wages reported on Withholding Statements for such wages and not more than $200 total of other wages, interest and dividends (excluding $50 of dividends). When this form is used, if the income was under $5,000, the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund. If the income was between $5,000 and $10,000 the taxpayer must compute his own tax.

Form 1040 is used if the income is less than $10,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Form 1040 must be used if the income was $10,000 or more. Separate schedules, in addition to Form 1040, are provided for reporting business and professional income, capital transactions and other income. They are Schedules C, D and B.

### Income-Splitting

Many physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

### Declaration of Estimated Tax

The provisions for filing declarations of estimated income taxes are principally for those persons, a substantial part of whose income is not subject to withholdings.

When filing a final return for 1962, on or before April 15, 1963, most physicians will be required to file a declaration of estimated tax for 1963 on Form 1040 - ES.

In general, if the income from sources other than wages subject to withholdings is over $200, the tax-

payer is required to file a declaration, unless his total estimated tax liability is less than $40.

Times to file declarations or amended declarations of estimated tax by individuals is April 15, June 15, September 15 and January 15. The date for filing an income tax return in lieu of a final payment of estimated tax is January 31. Thus, if an income tax return is not filed before February 1, the last day for filing declaration or an amended declaration is January 15.

If the estimated tax paid is 70 per cent or more of the actual tax liability, no penalty is assessed. For physicians who find it difficult to estimate their income in advance, it is suggested that they use the previous year's income as a basis and later file an amended declaration if the situation changes considerably.

### Physicians in Private Practice

To summarize, most physicians in private practice must comply with the following procedures.

1. On or before January 15, 1963, make a fourth quarter payment on declaration of estimated income for 1962.
2. On or before April 15, file a complete income tax return for 1962.
3. Pay the difference, if any, between the income tax paid quarterly and the amount of tax liability shown on the final return. If he has overpaid, the excess will be refunded or credited against future payments.
4. On or before April 15, file a declaration of estimated tax liability for 1963, and pay either the full amount or one-fourth of it. If he elects to pay quarterly, the remaining final dates for payment are June 15, September 15 (and January 15, 1964).

### Adjusted Gross Income

Individuals who are employed and receive a salary have little difficulty in ariving at the amount of their adjusted gross income. The total salary received plus amounts received from interest, dividends, rent, or from other sources, would in such cases constitute the gross adjusted income.

The physician in private practice has more difficulty in arriving at his adjusted gross income than the person on salary. From the amount of his cash receipts — if he reports income on the basis of cash received and disbursements, or on the amount of total charges if he uses accrual method of reporting his income — he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections:

### Deductible Business Expenses

**Office Rental** — If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he cannot claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office, and the proportion of operating expenses chargeable to the office.

**Automobile** — The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, bus, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is determined by dividing the cost price of the machine, less salvage value, by the number of years of its usefulness. Salvage value is the estimated amount that will be realized upon sale or disposition of the automobile at the end of its useful life — the useful life varying according to the policy of the taxpayer.

If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the number of miles the car is driven for professional purposes. If a physician possesses two cars, each of which is used partly in professional business the deductible depreciation on each car should be computed on the basis of the number of miles each car is driven for professional purposes.

The physician should seek the advice of a tax expert as to whether or not application of the "declining-balance method" (explained in the instructions which accompany the tax forms) would be advantageous to him.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is

> Data and advice presented in this article were obtained from official tax publications and from officers in respective taxing agencies. Although some of the tax analysis services were still in process of revising their publications as this issue went to press, every effort has been made to incorporate in this article 1962 changes in the Federal tax structure.
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> Nevertheless, physicians are advised to obtain supplemental advice and assistance in the preparation of returns from competent tax authorities or from staff members of respective taxing agencies. A tax expert may point the way to substantial savings as well as steer the taxpayer around embarrassing errors.
>
> Pamphlets and other aids for filing returns are available from some taxing agencies and from certain banks, etc.

not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

**Professional Dues** — Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted.

**Refresher Courses** — The Internal Revenue Service makes a distinction between expenses for advanced education and those for refresher courses (Sec. 1.162-5 of the Internal Revenue Service regulations).

The regulation provides that expenditures for education are deductible if they are for "refresher" or similar types of courses taken to maintain the skills directly and immediately required by the physician in his employment or practice. An educational course to be covered should be designed for established medical practitioners to help them keep abreast of current developments in the profession; it should be of short duration; it should not be taken on a continuing basis, and should not carry academic credit.

Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

**Travel Expenses** — When a physician travels away from home primarily to obtain "refresher" education or to attend a medical convention for professional purposes, his expenditures for travel, meals, lodging, etc., are deductible. However, expenses for personal activities such as sightseeing, social visiting, personal entertaining or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone. For example, if he and his wife have a double room, he may deduct the amount that he would have paid for a single room.

**Salaries and Wages** — Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

**Medicine, Supplies, Etc.** — Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

**Uniforms** — The Internal Revenue Service permits deduction of the cost of medical uniforms (garments, etc., necessary in practice but not suitable for street wear) as business expense.

**Depreciation** — Depreciation may be claimed on instruments, laboratory equipment, office furniture, books, etc., in fact, virtually all equipment and furnishings of more or less permanent value used in practice.

Important changes were announced in Treasury Department Publication No. 456 entitled *Depreciation, Guidelines and Rules*, issued in July 1962. Under new rules announced in this publication, the doctor may elect to write off all office furniture and equipment in 10 years; or he may write off depreciation under the old schedule based on estimated useful life of the article. Strictly scientific equipment with a useful life of less than 10 years may be written off under the old schedule.

New guidelines may be used in computing depreciation for the calendar year 1962 or for a fiscal year ending on or after June 30, 1962.

If the taxpayer is unfamiliar with methods of claiming depreciation, he may wish to consult a tax expert as to which method would be to his advantage — straight-line, declining-balance, double-declining-balance, or sum-of-the-digits method.

If improvements to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

Buildings used for business or professional purposes also are subject to depreciation deductions.

**General Office Expenses** — The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

**Debts** — If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i. e., all fees, either cash or account are included in income reported for tax purpose) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

**Taxes and Licenses** — State and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed, are deductible. Tenant-stockholders of cooperative

apartment corporations may deduct amounts paid to the corporation which represent taxes. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as nonbusiness deductions only.

Fee and expenses paid for "securing the right to practice" are not deductible, such as the fee paid to secure a license from the State Medical Board. Other license fees which the physician must pay, including narcotics registration and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business is to be taken as a nonbusiness deduction only. The tax paid on telephone bills if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills is not deductible. Federal taxes on amusements, club dues, furs and luxuries are also not deductible for Federal income tax purposes.

**Federal Old Age Benefits and Unemployment Compensation Taxes** paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

**Insurance Premiums** — Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

The United States Tax Court in a case decided in June, 1957, held that premiums paid by a doctor for disability insurance are **non-deductible** personal expenses, even where the policy is called a "Professional Income Policy." In the case before the court, there were no provisions in the insurance policies specifying that payments thereunder during disability were to defray or reimburse the holder for business or overhead expenses. Specific provision must be set forth in any policies of this type that the amounts will be for business or overhead expense in order to make the premiums deductible.

**Sales Tax Payments** — The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are nonbusiness deductions and not to be taken as business expenses.

**Ohio and Federal Gasoline Taxes** — The Ohio tax on gasoline is seven cents per gallon. The Federal tax on gasoline is four cents per gallon. If a physician has already included overall cost of gasoline as part of his business expenses, the tax is not again deductible. The Ohio tax paid on gasoline not used in business is deductible as a nonbusiness deduction. The Federal tax is deductible only as a business expense.

**Interest** — Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as nonbusiness deductions. Interest paid to carry tax free securities may not be deducted. The interest deduction may not exceed the portion of the total carrying charges attributable to the taxable year.

Carrying charges on installment purchases up to 6 per cent of unpaid balances are deductible where the taxpayer has carrying charge separately stated in installment sales contract.

**Losses by Fire and Theft** — Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

**Legal Expenses** — Expense incurred in the de-

### Taxpayer Identification Numbers Required for 1963 Returns

Under an Internal Revenue Service regulation issued August 24, 1962, any taxpayer filing a Federal tax return or related document on or after January 1, 1963, must show an "account number" in lieu of a Social Security number. An individual engaged in a trade or business is also required to obtain an identifying number which is termed an "employer identification number." A physician who employs help (other than domestic help) comes under the definition of an employer.

For physicians who do not have an account number, application should be made on either Form SS-5 or Form 3227. Application for an employer identification number should be made on Form SS-4. Forms are available from District Directors of Internal Revenue or from District Offices of Social Security.

On a return filed jointly by husband and wife, only the account number of the husband needs to be included in most cases. The wife's account number also must be shown if (1) she had separate gross income of $600 or more ($1200 or more if 65 years old); (2) she had self-employment income, (3) she had other income which the payer is required to report.

fense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible. The cost of contesting tax liabilities is deductible.

### Entertainment Expenses

Following are excerpts from a communication sent to a medical society in Mississippi by a District Director of Internal Revenue which the Law Department of the AMA says was one of the best explanations regarding deduction of physician's entertainment expenses it has seen:

1. A physician may deduct on his federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service, by appropriate evidence, that such expenses are ordinary and necessary business expenses and clearly related to the production of business income.
2. The amount of the deduction must be proved and its reasonableness determined. Once the amount is established, the deduction may be claimed when the doctor is able to show that the entertainment had a direct relationship to the conduct of his practice and can show the business benefit reasonably to be expected from the expenditure. The general statement that he hoped or expected to get referrals or patients as a result of the entertainments is not enough. If personal reasons predominate, the expenditure may not be deducted, even though there is some possibility of a business benefit. Except in the case of industrial physicians, entertainment of individuals who are not doctors will not ordinarily qualify because the possibility of benefits to be expected is so remote as to be negligible. In instances of the entertainment of patients, the same general rules apply as in the entertainment of other doctors, and the clear relationship of the expenditure to reasonably expected income must be shown. The same rules also apply to civic and other club dues.

Criteria to be used in establishing the deductibility of entertainment expenses include, but are not limited to, the following:

a. Specific purpose of entertainment. b. Nature of the practice of the doctor incurring the expenditure. c. Period of time the doctor has been in practice and the number of patients he already has. d. Percentage of his patients received as referrals. e. Names of individuals entertained and reason why additional income could reasonably be expected from each. f. Whether or not referrals were actually received from the doctors entertained and any indication of the effect of the entertainment on these referrals. g. Number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive. h. Whether or not other doctors in the same type practice in the locality have entertainment expenses.

### Exemptions and Allowances

An exemption of $600 may be claimed by the taxpayer for himself. He may also claim an exemption of $600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than $600 for the year. A child may earn $600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of $600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

### Nonbusiness Deductions

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, **providing that there is not a duplication of deductions under the two categories.**

**Contributions, Gifts, etc.** — The individual taxpayer may deduct contributions up to 30 per cent of adjusted gross income, if the last 10 per cent is given to a church, an association of churches, an educational institution or a hospital. The ceiling remains at 20 per cent for contributions to other charitable organizations, no substantial part of the activities of which

### Rules Tightened on Expenses For Entertainment, etc.

*The Journal* has repeatedly warned its readers about the importance of keeping detailed records on entertainment expenses claimed as deductions for tax purposes. Basic principles for deductions on entertainment, gifts and travel expenses are not changed under the Revenue Act of 1962, but many so-called loopholes are closed. Beginning in 1963, the Cohan rule, under which a business or professional man could make a reasonable estimate on these items, is out.

The physicians would do well to scan each item to determine that the expense was incurred principally in furtherance of the taxpayer's trade or business (profession) and then keep exact records.

are carrying on propaganda or otherwise attempting to influence legislation.

**Medical and Dental Expenses** — The taxpayer may deduct medical and dental expenses which exceed 3 per cent of the adjusted gross income. However, in figuring these expenses, the amount paid for medicine and drugs may be taken into account only to the extent it exceeds 1 per cent of the adjusted gross income.

The deduction may not exceed $2,500 multiplied by the number of exemptions other than the exemptions for age and blindness. In addition there are maximum limitations as follows: (a) $5,000 if the taxpayer is single and not a head of household or a qualifying surviving widow or widower; (b) $5,000 if the taxpayer is married but files a separate return; or (c) $10,000 if the taxpayer files a joint return, or is a head of household or a qualifying surviving widow or widower.

If the taxpayer or his wife is 65 or over, the maximum limitations are the same as in the foregoing paragraph. However, amounts deductible for medical and dental expenses are not restricted to the excess over 3 per cent of adjusted gross income. In effect, the 3 per cent rule may be disregarded. But the amounts spent for medicine and drugs are still limited to the excess of 1 per cent of income, and amounts spent for dependents' medical expenses are deductible only to the extent they exceed 3 per cent of adjusted gross income.

The 3 per cent rule may be disregarded for the medical expense paid for the care of a dependent father or mother if past 65 years of age before the end of the taxable year.

Medical expenses paid by an estate within one year after death are considered paid by the decedent.

The term "medical care" is broadly defined to include "amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurances)."

In regard to payment of premiums on accident and health insurance, the Internal Revenue Service has ruled that premiums may be deducted for insurance that provides for indemnity for the cost of medical care and specific injury, but may not be deducted for insurance which indemnifies the holder solely for the loss of earnings.

**In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and amount. It should be noted that this will furnish the Internal Revenue Service with data which can be used in checking returns filed by physicians and dentists — another reason why they should keep accurate records and compile their returns carefully.**

**Interest** — The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

**Taxes** — Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, auto license fees, state gasoline taxes.

**Casualty Losses and Thefts** — The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, if not claimed as a business deduction and not covered by insurance.

### Optional Standard Deduction

The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes, and other nonbusiness deductions is 10 per cent of the adjusted gross income, but not in excess of $1,000; or $500 in the case of a married person filing a separate return.

### Partnerships

The partnership itself is not subject to income tax, but is required to file an information return, Form 1065. Tax liability falls upon the individual partners. Simple agreements for the sharing of expenses, coownership and maintenance of property, and the like, are not considered partnerships, unless a profit element also is involved.

Where an actual partnership exists, partners would do well to seek expert advice in regard to tax liability. An Opinion of the Attorney General given in 1961 permits professional men to associate as partnerships under Ohio limited partnership law and thus make themselves eligible for favorable tax action under the U. S. Internal Revenue Act.

### Professional Corporations

On October 17, 1961, there came into effect for the first time in Ohio a law which permits one or more physicians to incorporate a professional association. A number of Ohio physician groups have taken advantage of this law under which certain tax benefits may be claimed. In considering incorporation of a professional group, physicians should study both advantages and disadvantages of such a move with the help of legal counsel.

### Retirement Income

Retirement income, including pensions, annuities, interest, rents, dividends, etc., are subject to special treatment under the income tax laws.

### Jenkins-Keogh Bill Provisions

The Jenkins-Keogh Bill recently passed by the Congress and signed by the President becomes effective for taxable years after December 31, 1962. Tax-

payers, therefore, should disregard it in computing taxes for 1962.

The new law will permit physicians and other self-employed persons to claim tax deductions for contributions made by them to pension and retirement plans for themselves and their employees. For a discussion of provisions and restrictions of the law, refer to November issue of *The Journal,* page 1286.

### District Offices and Districts

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are two districts in Ohio. Counties comprising each district follow:

**For the Cincinnati District (Ohio 1st)** — Director of Internal Revenue, 700 Walnut Street, Cincinnati 2, Ohio, comprising the following counties: Adams, Athens, Brown, Butler, Clark, Clermont, Coshocton, Clinton, Delaware, Fairfield, Fayette, Franklin, Greene, Guernsey, Hamilton, Highland, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Miami, Montgomery, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Preble, Ross, Scioto, Union, Vinton, Warren, and Washington.

**For the Cleveland District (Ohio 18th)** — Director of Internal Revenue, 626 Huron Rd., Cleveland; comprising the following counties: Allen, Ashland, Ashtabula, Auglaize, Belmont, Carroll, Champaign, Columbiana, Crawford, Cuyahoga, Darke, Defiance, Erie, Fulton, Geauga, Hancock, Hardin, Harrison, Henry, Holmes, Huron, Jefferson, Lake, Logan, Lorain, Lucas, Mahoning, Medina, Mercer, Monroe, Ottawa, Paulding, Portage, Putnam, Richland, Sandusky, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Wayne, Williams, Wood, and Wyandot.

## INCOME TAX WITHHOLDINGS

Every employer who pays wages to one or more employees, where an employer - employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941T, quarterly during the month immediately following the quarter for which deductions are made. (Social Security taxes are reported on this same form.)

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941T, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

### Deposit of Withholdings

An employer who withholds as much as $100 per month for the purposes of income tax liability and F. I. C. A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depositary receipt, Form 450, is then eligible for use.

### Report of Funds Paid

As in previous years, payments in excess of $600 made during the year for interest, rents, or commissions, not subject to withholdings and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 28 of the following year to the Director, Midwest Service Center, 1400 East 95th St., Kansas City 31, Missouri.

## SOCIAL SECURITY TAXES

The Federal Social Security Act embodies law pertaining to, (1) Old Age, Survivors' and Disability Insurance, and (2) Unemployment Insurance. Following a general discussion of Social Security coverage, these two tax categories are discussed separately, since the procedures for paying them are different.

**Under the provisions for coverage of self-employed workers, physicians are specifically excluded.** As employers, however, physicians will be interested in provisions of the law.

For the benefit of those who employ persons now receiving Social Security benefits, the following provisions are presented. A worker under age 72 will not lose any benefits unless he makes over $1200 a year. If he does make over $1200 a year, the total amount of benefits payable to him and the members of his family getting benefits will be reduced as follows: (1) If his total earnings are not more than $1700, one-half of the amount over $1200 will be deducted; (2) if total earnings are more than $1700, then $250 plus all of the amount over $1700 will be deducted.

Men may now elect to receive benefits at age 62 with somewhat reduced rates, or at age 65 with full

benefit rates. Women have this same privilege, as they have had in the past.

Not covered for social security purposes is work done by a child under 21 for his parent, by a husband for his wife, or by a wife for her husband. This applies also to foster or step-relationships. Services performed by or for "in-laws" and relatives other than those named are covered provided a genuine employment relationship exists.

Under current provisions, work that a parent does for a son or daughter in the course of a trade or business is covered by Social Security. However, work done in the household of a son or daughter is not covered.

Domestic workers in private homes who receive wages of at least $50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns $50 or more in a quarter (approximately $3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns $150 in cash wages during the year must be covered. However, farm workers who perform agricultural services for an employer on 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

### Old Age, Survivors' and Disability Tax

The Old Age, Survivors' and Disability Insurance Tax is payable by every employer who employs **one or more persons** in his office or home.

For the calendar year 1962 the employer deducts 3⅛ per cent from the employee's wages up to $4800, and contributes another 3⅛ per cent himself.

**Beginning January 1, 1963 the amount is raised to 3⅝ per cent, each for employee's and employer's contribution. The ceiling remains at $4800.**

The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed on or before April 30, for the months of January, February and March of that year, in the office of the District Director of Internal Revenue, and quarterly thereafter, payable during the month after the quarter ends.

The employer who hires household help only should file on Form 942, which is in the form of an envelope for convenient mailing. The employer who reports his office workers on Form 941 may add his domestic workers to this same form.

Farm workers must be reported on Form 943.

### Unemployment Tax

Physicians or other employers who have **three or more** employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax. Those who have **four or more** are liable also for the Federal Unemployment Insurance Tax.

In professional associations incorporated under Ohio S. B. 550, members of the group are counted as employees.

### Ohio Unemployment Compensation Tax

In general, employment of **three or more persons** renders the employer liable for this tax. (Excluded from the number of employees is a minor who does short-time work but whose principal occupation is that of student; an extra worker who works not more than one day in a week; also a person doing casual labor not in the course of the employer's regular business.) A physician who is in doubt as to his liability, should request clarification from the Bureau of Unemployment Compensation, 427 Cleveland Ave., Columbus 16.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This shows how the rate for the employer for that year was calculated. This rate starts at 2.7 per cent and may be reduced to as low as one-tenth of one per cent. Only the first $3,000 paid by any employer to any one individual "in employment" within a calendar year is taxable.

For the tax years 1962 and 1963 an emergency rate of 0.5 per cent is effective, making the minimum rate 0.6 and the maximum rate 3.2 per cent.

Penalties are specified in the Ohio Code for failure to comply with provisions of the law.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the Bureau will request separation and wage information from the employer. It is imperative that this form requesting separation information be returned to the Bureau within seven days of its receipt.

### Federal Unemployment Tax

The Federal Unemployment Insurance Tax applies to employers who have had **four or more persons** on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year. The gross tax is 3.1 per cent on all individual wages up to $3,000 and is paid exclusively by the employer — the employee making no contribution. A credit not to exceed 90 per cent of this tax is allowed on all payrolls which were reported to the state unemployment compensation agency, (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax rate in full, the Federal tax is reduced to four-tenths of 1 per cent. For 1962 and

1963 an additional four-tenths of 1 per cent is imposed on all employers subject to the Federal law in order to pay for the special emergency extended benefits program. This brings the amount paid to the Federal government in 1962 and 1963 up to 0.8 of 1 per cent.

## OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing **three or more** employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of **less than three** employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by September 1 for the first half of the year, and by March 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation comprises 16 regional offices in addition to the central office in Columbus.

### Disabled Workmen's Relief Fund

Effective August 1, 1959, the Ohio General Assembly increased permanent and total disability benefits from $25.00 to $40.25 per week and enacted Senate Bill No. 472 to finance this increase by levy of an excise tax on employers of 3 cents per $100 of total aggregate gross payroll. This excise tax applies to employers of three or more employees, and to employers of less than three persons who have voluntarily subscribed to the Workmen's Compensation Insurance Fund. Report for the calendar year with premium is due by March 1 of the following year.

## OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 30 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its book value. Counting the year of purchase as a half year, a depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 2½ per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

When a physician opens his practice (or a person starts in business) during the calendar year, he is required by law within 90 days of time of opening to list all his taxable property, as of the date he engaged in practice. The valuation of all taxable property to be returned for taxation is determined by multiplying the value by the number of months the taxpayer has been in practice and dividing by 12.

Forms 937 and 902, obtained from the Ohio Department of Taxation, must be filed with the Personal Property Tax return to obtain a lesser value than 20 per cent.

**Returns should be filed in duplicate.** The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

**Accounts receivable are to be listed in accordance with Section 57711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.**

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually, or the last day of the fiscal year.

**As defined in Section 5701.07 R. C., credits mean "the excess of the sum of all current accounts receivable and prepaid items used in business when**

added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

It should be understood that there is no descrimination in the foregoing provisions against physicians. Every person who possesses intangible assets, such as accounts receivable, or any business or professional man who does business on a credit basis, must return his accounts receivable for taxation.

### OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

In Section 5739.01, under the definition "vendor," the Revised Code states: "Physicians, dentists, hospitals and veterinarians who are engaged in selling tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, are vendors."

Under the definition of "consumer," the Code states: "Physicians, dentists, hospitals, and blood banks operated by non-profit institutions and persons licensed to practice veterinary medicine, surgery and dentistry are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, the rendition of hospital or blood bank service or the practice of veterinary medicine, surgery and dentistry."

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by next April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

### CITY PAYROLL TAX

Scores of municipalities in Ohio have enacted laws imposing income tax on wage earners and making the employer responsible for deducting the tax from wages and making returns to the local government.

A physician who moves into a new location would do well to inquire as to what tax laws may be in force locally.

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### Rules Labs Can Send Ad Material To Physicians

Advertising practices of physician-run medical laboratories have been found "acceptable" by the Judicial Council of the American Medical Association, which analyzed advertising material collected from a number of states, including Ohio.

The study was undertaken by the Judicial Council when it received reports that some MD-run laboratories were mailing material advertising the laboratory services to doctors' offices.

The Council's opinion said, "The advertising is acceptable because the advertising material is directed from doctor to doctor, and does not go to patients or to the public. **However, no schedule of fees may be included in such advertising material.**"

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### American Public Receiving Increased Benefits from Health Insurance

The American public received an average of $2.3 million a day during 1961 from insurance companies to help replace income lost through illness or injury, the Health Insurance Institute reports. These loss-of-income benefits were apart from benefits paid toward hospital, surgical and medical bills by insurance companies and other insuring organizations.

Last year benefits by all insuring organizations to pay health care bills totaled $5.5 billion. Loss-of-income benefits from insurance companies amounted to $855 million for a grand total of $6.3 billion. The loss-of-income benefits do not include accidental death and dismemberment payments.

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# Coming Meetings . . .

**Ohio State Medical Association,** 1963 Annual Meeting, Cleveland, May 12-17.

**Academy of Medicine of Cleveland and Cleveland Bar Association** joint meeting to hear Dr. Edward R. Annis, December 10.

**American College of Physicians,** Postgraduate Course No. 8, Diseases of the Blood Vessels and Problems of Thrombo-embolism, January 21-25, Cornell University Medical College and New York Hospital, New York City.

**American Laryngological and Otological Society,** Middle Section Meeting, Cleveland, January 13-14.

**Cleveland Clinic Education Foundation,** Newer Developments in Ophthalmology, December 5-6.

# More Subscribers Buying Better OMI Contracts

By R. DEAN DOOLEY, M.D.
Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

IT is interesting to note the gradual decline in the number of Ohio Medical Indemnity Standard Contracts with a corresponding increase in our better programs. The increase in the number of Major Contracts is especially gratifying. December, 1960, was chosen for the beginning of the study. At that time 71 per cent of all our subscribers were insured under our Standard Contract. By June 30, 1961, the Standard subscribers had fallen to 66 per cent and in December, 1961, reached a level of 60 per cent.

By September of 1962, the Standard Contracts had declined to 56 per cent of our total. These figures reveal a steady and measurable conversion of our Standard subscribers to more realistic protection provided in our better contracts.

Some of my readers may register impatience at the lack of speed indicated by these figures, but it must be understood we can only move as fast as the law permits us. We have a responsibility to our subscribers which we dare not abandon. I can assure you we are moving as rapidly as the circumstances and sound practice permit. It is to be hoped that the new program developed by the Ohio State Medical Association will soon be in operation and that it will replace all our existing contracts so that the Standard Contract will remain only as a fact of history.

Ohio Medical Indemnity will be the first to admit that our Standard Contract is completely out of step with today's economy. While our progress in replacing the contract with better ones has not been as great as we would like, the shortcoming has not been due to our lack of recognition of the problem.

The Preferred Contract was designed to provide better coverage. It was hoped that conversion from the Standard to the Preferred Contract would be spontaneous and rapid. Unfortunately, such was not the case. The constantly rising hospital costs added to the total cost of the health insurance package so there was a reluctance on the part of individuals and groups alike to absorb higher Blue Shield premiums necessitated by the better contract. Also the objection was voiced that the increase in premium occasioned by better contracts carried no assurance that the protection afforded justified the increased expenditure. Consequently, the Major Contract was developed in 1958 with the expectation that it would counter the objections used against the Preferred Contract. It is now history that the Major Contract also was handicapped by lack of guarantees.

By 1959 it was manifest that drastic action must be taken. The first step was removal of the Standard Contract from the market to new groups. Groups already insured were allowed to keep it and new employees coming into these groups were privileged to be insured under the existing program. Plans were projected to effect the conversion of all direct-pay subscribers by an established date in conformity to existing insurance laws. We were immediately confronted with the problem of multiple effective dates, inasmuch as refusal to renew a contract could only be made at the termination of a contract year. This posed an administrative task of awesome magnitude.

Also, many groups were limited in the amount of funds they could use for health insurance purposes and a premium increase would force them to drop our program and replace it in a commercial carrier.

Taking all the facts into consideration, the Board of O.M.I. decided the best approach would be voluntary and, in keeping with that philosophy, they recommended a course of action to accomplish gradual conversion without resort to compulsion. We believe the results have confirmed the wisdom of the Board in taking this approach.

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Hiram College is giving a series of medical lectures of general public interest under sponsorship of the health service and departments of biology, chemistry and physics. Lectures were given in October and November, and additional talks are scheduled in January, March and April. Members of the Portage County Medical Society are participating in the project.

# 1963 OSMA Annual Meeting Features

## All Events To Be Under One Roof at the Remodeled Sheraton - Cleveland Hotel. Cleveland. May 12 - 17

**Western Reserve University Feature:** The faculty of Western Reserve University School of Medicine will sponsor a leading feature of the 1963 OSMA Annual Meeting in Cleveland, on Friday, May 17. Beginning at 9:30 a. m., Dr. John Michael Moses, Department of Medicine, University Hospitals, will speak on "The Etiology of Fever." Beginning at 11:00 a. m. Dr. Martha L. Lepow, assistant professor of pediatrics, Western Reserve, and the Department of Pediatrics, Metropolitan General Hospital, will discuss "Current Problems in Immunization Against Measles."

Other scientific features are the following:

**Specialty Societies:** Most of the specialty societies in Ohio will hold meetings during the week. Most of them will combine with the Specialty Sections of the Ohio State Medical Association in presenting scientific programs for all OSMA members. They also will hold their own business and social events.

**Heart and Cancer Programs:** A General Session on cancer will be presented at 2 p. m., Tuesday, May 14, by the Ohio Division, Inc., American Cancer Society. A General Session on heart disease will be presented at 2 p. m., Wednesday, May 15, by the Ohio State Heart Association.

**Fireside Conferences:** The American College of Chest Physicians and its Ohio Chapter will again this year present the informal fireside conferences at the 1963 meeting, scheduled for 8 p. m., Thursday, May 16.

**"How I Do It":** An all new feature for 1963 will be the "How I Do It" sessions Thursday morning. Experts will tell how they do bone marrow biopsy and an emergency tracheotomy; how they deal with nasal hemorrhage, and with small bowel obstruction; how they handle status asthmaticus, brittle diabetes, and a lump in the breast.

**"What's New?":** Again in 1963 a general session on "What's New?" will be a popular part of the meeting. This session will be held on Thursday morning, May 16.

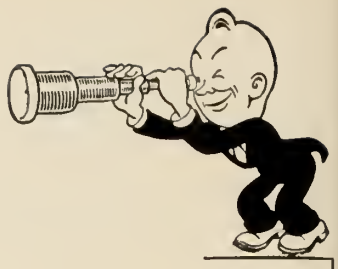
The House of Delegates will meet on Sunday evening, May 12, and on Wednesday morning, May 15. Resolutions Committees will meet on Monday morning, and again on Tuesday if necessary.

Social event of the Annual Meeting will be the President's Reception on Wednesday evening, May 15, for members attending the Meeting.

An excellent Scientific and Educational Exhibit, as well as an outstanding Technical Exhibit will also be features of the meeting. Make your plans now to attend by reserving the dates and making your hotel reservations in advance.

**All Events Will Be on Eastern Daylight Saving Time**

# Looking Ahead . . . . .



## Hotel Reservations

### Are Now in Order

**For the 1963 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION. Assure yourself and party excellent accommodations by filling out the coupon below NOW and mailing it to the hotel of your choice. The place is CLEVELAND; the dates, MAY 12 - 17, 1963.**

| NAME AND LOCATION | SINGLE | DOUBLE | DOUBLE TWIN BEDS |
|---|---|---|---|
| SHERATON-CLEVELAND HOTEL, Public Square (Headquarters Hotel) | $7.85-15.50 | $11.85-17.50 | $14.00-21.00 |
| AUDITORIUM HOTEL, 1315 East 6th St. | 5.50-10.00 | 8.50-12.50 | 12.50-13.50 |
| PICK-CARTER HOTEL, Prospect & E. 9th St. | 6.50-12.00 | 10.50-16.00 | 12.00-16.00 |
| STATLER HILTON HOTEL, Euclid & E. 12th St. | 6.50-14.50 | 13.00-16.00 | 14.00-30.00 |

Persons who desire additional accommodations are advised to specify their needs to the hotels of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK
Mail the coupon to hotel selected

Manager _____ , Cleveland, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 12-17, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price _____

☐ Twin Bed Room with Bath ☐ Suite

Arriving May _____ at _____ A. M. P. M.

PLEASE VERIFY MY RESERVATION

Name _____

Address _____

# APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1963 ANNUAL MEETING, SHERATON-CLEVELAND HOTEL, CLEVELAND, OHIO, MAY 12-17

1. Title of Exhibit: _____

2. Name(s) of Exhibitor(s): _____

_____

Institution (if desired): _____

City _____

3. Do you have a built-in exhibit? _____

4. Description of Exhibit: **(Attach 200 word description to this blank)**

5. Exhibit will consist of the following: (Check which)

Charts and posters ____ Photographs ____ Drawings ____ X-rays ____

Specimens ____ Moulages ____ Other material _____
(Describe)

6. Booth Requirements:

Amount of wall space needed? _____

Back wall ____ Side walls _____

Square feet needed? _____

Shelf desired? (yes or no) _____

7. Transparency Cases:

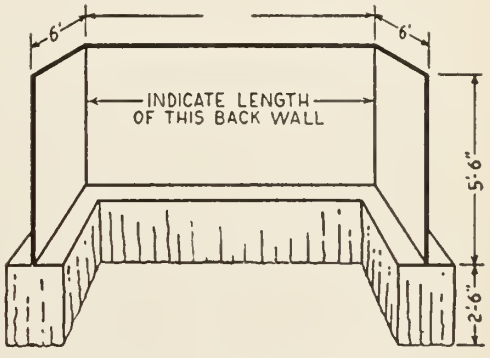
Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____

_____

_____




*Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.*

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association" which will be supplied to all applicants.

Date _____

_____
Signature of Applicant

_____
Mailing Address, Street

_____
City, Zone, State

**SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO.**

**DEADLINE FOR FILING APPLICATIONS, FEBRUARY 15, 1963**

# Mental Illness Proposals . . .

## Large Ohio Delegation Participates in AMA National Meet. Recommends Buckeye State Action Program

A SEVEN-PART SERIES of recommendations for an Ohio mental health program was formulated by a 117-member delegation of Ohioans participating in the American Medical Association's first National Conference on Mental Illness and Health in Chicago October 4-6.

The recommendations will be considered by the Committee on Mental Hygiene of the Ohio State Medical Association and a report presented to The Council of the association after the proposals have been thoroughly digested.

### Educational Suggestions

In the field of medical education, the delegation recommended that Ohio's schools expand undergraduate teaching in the behavioral sciences; that the AMA Council on Medical Education and Hospitals seek closer contact of interns and residents with the care and treatment of mentally ill patients; that continuing education of general practitioners be promoted through the OSMA and county societies.

In community mental health, the group recommended that central hygiene committees be established in those county medical societies that do not now have them, and that the resources of the OSMA Woman's Auxiliary be utilized.

### Insurance Expansion Asked

In patient care, it was recommended that Blue Cross, Blue Shield and similar insurance plans be expanded and made more uniform to cover patients suffering mental illness. Emphasis was given to adequate staffing of all mental health facilities, including psychiatric units in general hospitals, rather than merely building new facilities.

The group reported that Ohio laws related to admission to mental hospitals are "in the vanguard," but called for further study of laws relating to guardianship, property rights and competency. Recommendation for a separate Ohio Department of Mental Health was generally supported, but not unanimously.

### Financing

The group endorsed the principle of multiple source financing, called for an Ohio medical profession well informed on financial needs of state programs, and recognized that "the local community should bear a share of the burden through local taxation," such as is used to help finance community mental health services.

The delegation recommended that five per cent, instead of the present two per cent, of the total Ohio mental health budget be allocated for research, and suggested that part of the state's receipts for patient care could help finance research.

### Suggest Organization

In concluding the recommendations, the group reported, "It was decided that the Ohio Delegation should continue as an active group under the guidance of the Ohio State Medical Association. It was proposed that staff assistance be made available to the Committee on Mental Hygiene of the OSMA and that liaison be maintained with the Ohio Delegation to the Congress through this means. A future meeting and further planning were enthusiastically approved."

The Congress opened with an orientation, followed by study sections in more than 20 categories, after which the various state delegations met separately for evaluation and recommendations.

This then was followed by a report of states in general session.

### Those Participating

Dr. Dwight M. Palmer, Columbus, chairman of the OSMA Committee on Mental Hygiene, headed the Ohio delegation. Other committee members who registered for the Congress included Drs. W. N. Koontz, Newark; J. Robert Hawkins, Cincinnati; Charles W. Harding, Worthington; Ewing H. Crawfis and Victor M. Victoroff, both of Cleveland.

Other Ohio physicians registered included Drs. James R. Hodge, William H. Holloway, Herbert Kern, and Basil D. Roman, Akron; A. P. Dell Cort, Brecksville; A. Arnold Kippen, Canton; Stanley M. Kaplan, Othilda Krug, Maurice Levine, Max L. Lurie, James A. L. Moulton, Richard E. Wolf and Ohio Psychiatric Association President Philip E. Piker, all of Cincinnati;

Irving L. Berger, Charles J. Centa, J. Patrick Duffy, Raymond N. Ferreri, Edward N. Hinko, Louis D. Kacalieff, Charles L. Langsam, Bernard S. Mat-

thews, Irwin N. Perr, A. Dixon Weatherhead and Vincent T. Wrobel, all of Cleveland;

William P. Addison, Arnold Allen, Lowell O. Dillon, Jaime Smith e Incas, Walter Knopp, Ohio Mental Health Commissioner Henry Luidens, Ralph M. Patterson, Irving Pine, and Philip C. Rond, Jr., all of Columbus; James N. Cunningham and M. T. Faruki, Dayton; Edward Kezur, Hamilton; David W. Sprague, Lakewood; Theodore J. Reshetylo, Lima; Walter A. Massie, Mansfield; Max D. Graves, Springfield; Olgierd C. Garlo, Tiffin; Henry L. Hartman and Wilson P. Shortridge, Toledo; John J. Smith, Wickliffe, and George T. Harding, Worthington.

Among organizations represented at the Congress were the Ohio Mental Health Federation, the Ohio Mental Health Association, and the Ohio Association of Probate Judges, in addition to the Ohio State Medical Association.

# New Members . . .

The following are the names of new members of The Ohio State Medical Association since October 1, 1962. The list shows the county in which they are practicing or temporary address in cases where physicans are taking postgraduate work.

**Butler**

Louis L. Barich, Hamilton
Edwin L. Helfman, Middletown

**Cuyahoga**

Jeanine K. Balin, Willoughby
Arthur Barnes, Cleveland
Bernard Barron, Bedford Heights
Robert T. Breckenridge, Cleveland
Renato Cutarelli, Cleveland
Cornelio B. Deogracias, Cleveland
James E. Foerstner, Cleveland
Avrum I. Froimson, Cleveland
Parrish W. Garver, Cleveland
Sheldon G. Green, Cleveland
Kemal Gursal, Cleveland
Walter E. Heyse, Cleveland
R. Thomas Holzbach, Cleveland
Donald J. Kellon, Cleveland
Hans Leen, Cleveland
Edward M. Lees, Cleveland
Julio L. Levy, Cleveland
Allen H. Mackenzie, Cleveland
Aladar E. Mako, Cleveland
Hermann Menges, Jr., Cleveland
Salvatore Miano, Cleveland
Roland W. Moskowitz, Cleveland
Paula B. Mulligan, Cleveland
Tarik O. Muskara, Cleveland
Joseph H. Myers, Willoughby
Ralph A. Nelson, Cleveland
Norman L. Pearl, Cleveland
James A. J. Pelagalli, Cleveland
Oscar C. Reyes, Cleveland
Norman L. Roulet, Cleveland
Leonard A. Scharf, Cleveland
Roland J. Schoeck, Cleveland
Stanley H. Shensa, Cleveland
O. David Solomon, Cleveland
Mervyn D. Sopher, Cleveland
Emerald B. Spencer, Cleveland
Nicholas Timchinov, Cleveland

Cuyahoga *(Continued)*

Louis J. Tornambe, Cleveland
Robert J. White, Cleveland
James J. Whitford, Cleveland
Daniel W. Wingard, Cleveland

**Greene**

Richard L. Miller, Xenia

**Guernsey**

Miroslaw W. Hnatiuk, Senecaville

**Lorain**

Nicandro V. Leano, North Ridgeville

**Lucas**

Raymond R. Buganski, Toledo
Homer A. Caruso, Toledo
John A. Devany, Toledo
Joseph Mann, Toledo
Harry E. Nicholson, Jr., Toledo
Norman J. Sacks, Toledo

**Muskingum**

Dominic B. Brune, Zanesville
William Davy Smith, Zanesville

**Portage**

William R. Brinker, Kent

**Sandusky**

Jesus F. Pascua, Clyde

**Summit**

Adelbert A. Kostensky, Akron
John C. Kyle, Akron
John H. Spillane, Akron

**Wayne**

Roger C. Moyer, Wooster

## Activities of Rural Health Committee Reported

The Council of the Association meeting on November 11 received a report on a meeting of the Committee on Rural Health held on October 17. The report was presented by Mr. Charles W. Edgar, committee secretary, to The Council on November 11.

Mr. Edgar reported that the Special Talks for Medical Students will be held at The Ohio Union for The Ohio University College of Medicine Seniors Saturday, January 26, and at the Cincinnati Academy of Medicine for University of Cincinnati College of Medicine Juniors Sunday, February 10. The committee also decided that special emphasis should be placed on the OSMA preceptorship program as a part of the afternoon session.

The committee voted to distribute a leaflet on preceptorship to Cincinnati juniors during the February 10 program, and to mail the leaflet to juniors at Ohio State. It further decided that the program should limit preceptorship to the student only, and that it be clearly pointed out to the students that the question of participation by their wives and families is to be determined solely by the preceptor, who is to inform the student whether or not he can accept the student's wife or family during any or all of the preceptorship period.

Dr. Rafey presented a tentative outline for a 4-H Club community immunization program which 4-H Club members could use as a project of encouraging adults in their community to be immunized and to obtain booster shots, with special emphasis on tetanus. Copies of the outline were distributed to Committee members and the Chairman requested them to review the outline and return it, along with suggestions, to the Committee secretary.

The chairman reported to the committee that there had been some suggestions that the name of the Committee might be changed in order that medical students would not look on its programs for the students as solely a rural practice approach to medicine. After some discussion, the Committee voted to retain the current name of the Committee as this title is truly representative of the committee's activities. It further decided that program emphasis on the medical students programs should minimize the Rural Health Committee and emphasize OSMA as a means of overcoming the rural practice inference.

## Papers for AMA Meeting

The Council on Scientific Assembly invites physicians to submit titles and brief abstracts of scientific papers they wish to deliver at the 1963 annual meeting of the American Medical Assocition, which will be held in Atlantic City, June 16-20. The deadline is December 15.

# Payment-in-Full Plan . . .

## First Draft of Suggested Proposal Sent to OAGP and Specialty Organizations for Review and Suggestions

FIRST draft of a suggested Ohio State Medical Association Payment-in-Full Medical and Surgical Insurance Plan is now in the hands of various medical organizations throughout the state for study.

The medical specialty groups of the state and the Ohio Academy of General Practice have been requested to send criticisms, comments and suggestions to The Council.

A copy of the suggested plan, drafted by The Council during the past several months, also was sent to the president of each County Medical Society with a covering letter reading in part as follows:

### Letter to County Presidents

"The purpose of this letter is to keep you up to date on progress which is being made in carrying out the mandate of the House of Delegates with regard to the establishment of a payment-in-full medical and surgical insurance plan by the Ohio State Medical Association.

"The tentative proposal enclosed was formulated by The Council as a starter. A copy of the tentative plan has been sent to the president of each specialty organization in Ohio and to the President of the Ohio Academy of General Practice. They have been requested to offer comments and criticisms. The Council is asking for help in formulating the best possible plan.

"Their replies will be given careful study and consideration by The Council in re-drafting and re-finishing the proposal.

"After The Council has drafted what it hopes will be a plan acceptable to the overwhelming number of members of the Ohio State Medical Association, the entire membership will be given the opportunity to express itself for or against the proposal."

### Deadline is January 1

The Council hopes to hear from the medical groups on or before January 1, 1963. Soon after that date, The Council will review all suggestions received and will begin formulating a final draft which will be sent to all members of the Ohio State Medical Association so members can express themselves for or against the proposal.

Following is the text of the foreword of the brochure describing the suggested plan, carrying the signature of Dr. Geo. J. Hamwi, president of the OSMA:

### House of Delegates Action

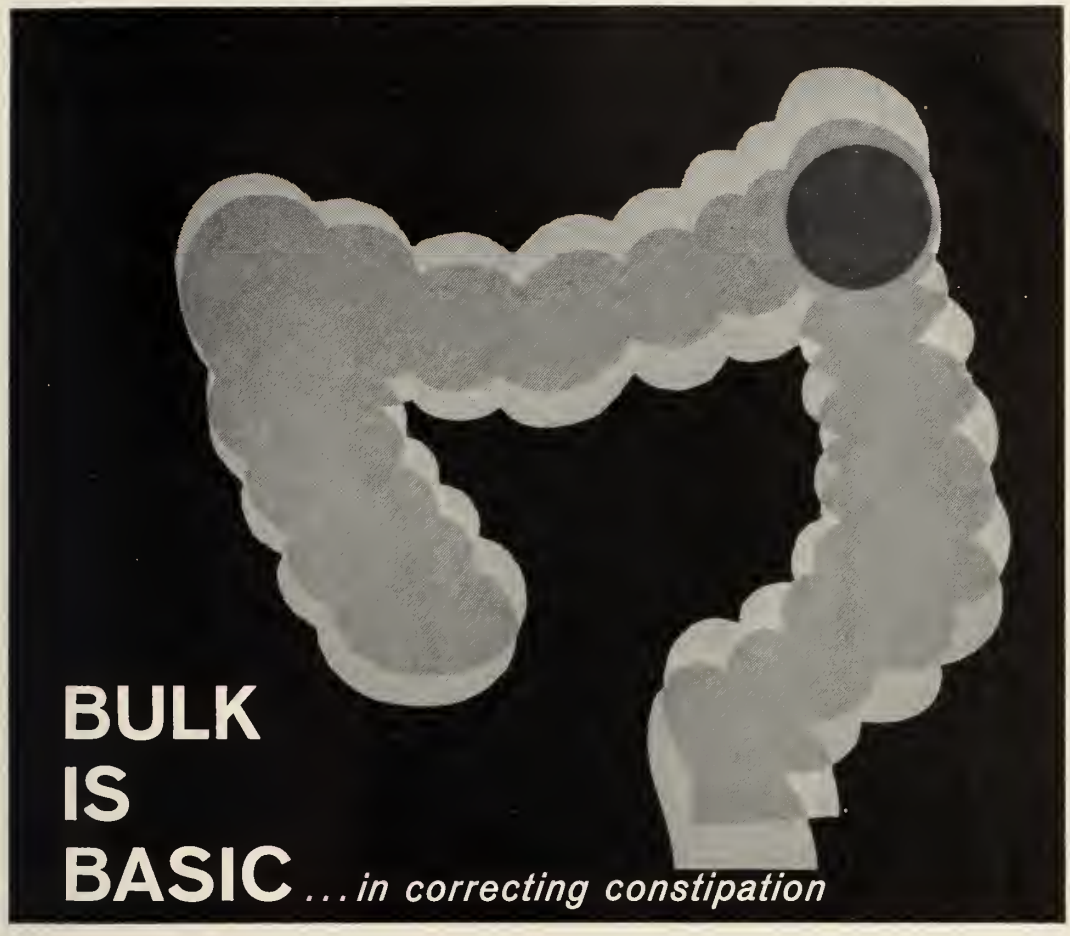
"This suggested draft for an Ohio State Medical Association payment-in-full medical and surgical insurance plan has been formulated by The Council of the Association pursuant to action by the House of Delegates of the Association in May, 1962, endorsing payment-in-full insurance contracts for groups who qualify by certain income limits.

"In developing this proposal, The Council has analyzed the provisions of Blue Shield plans throughout the country, including Ohio's Blue Shield plans, Ohio Medical Indemnity and Medical Mutual of Cleveland, as well as insurance programs covering employees of many key industries, such as steel, rubber, auto and public employees. Many of the provisions of those experienced programs have been used as the basis for the plan herein presented.

### Proposed Income Limits

"The suggested Ohio State Medical Association plan is designed to provide scheduled indemnity payments for certain medical and surgical services explained in detail in this proposal, which voluntarily participating physicians would agree to accept as payment-in-full when such services are rendered to members of families with a gross family income of $7500 or less and single persons with a gross income of $6500 or less. For subscribers whose gross income exceeds the agreed limit the scheduled indemnity benefits need not be accepted by the participating physician as payment-in-full. In such cases the scheduled indemnity payment will be made and the balance, if any, of the physician's bill, will be the responsibility of the patient. Likewise, if services are rendered by a non-participating physician the scheduled indemnity payment would be made and the balance, if any, of the physician's bill will be the responsibility of the patient.

"The data on Ohio studied by The Council revealed that of the 2,944,089 households in the State (household being an occupied dwelling unit and in-




# METAMUCIL®

BRAND OF PSYLLIUM HYDROPHILIC MUCILLOID

## STRENGTHENS THE COLONIC REFLEX

***"The natural stimulus to peristalsis[1]... is the distension of the intestinal wall...."***

The effectiveness of Metamucil in correcting constipation is a direct result of its physiologic action.

The stimulus which initiates the defecatory reflex is the fecal mass in the lower sigmoid colon and rectum. Metamucil provides that mass as a bland, nonirritating, easily compressed bulk, similar in consistency to the normal protective mucus of the colon. Taken regularly, Metamucil tends to correct the insensitive reflex of a bowel abused by laxatives and to restore the natural responsiveness to the urge to stool.

Metamucil is available as Metamucil powder in 4, 8 and 16-oz. containers and as lemon-flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

G. D. SEARLE & CO.

CHICAGO 80, ILLINOIS

*Research in the Service of Medicine*

cludes all persons living in this unit) 65.62 per cent had a gross income of less than $7500.

### Frequent Review

"The Council has decided that the plan finally adopted shall be reviewed every two years in order to make adjustments and modifications in the plan as may be deemed necessary to keep abreast of changing economic conditions.

"Any insurance company licensed to write this type of coverage in Ohio will be given an opportunity to participate in the underwriting of the plan provided such company can meet the specific requirements of the contract and of such regulations as may be adopted by the Ohio State Medical Association for governing the plan.

"An effort has been made in formulating the plan, to adhere to the following fundamentals: The plan must be simple and relatively free of troublesome exclusions and waiting periods (except obstetrics). It must pay as nearly as possible the current charges of physicians for the services rendered. The coverage must be sufficiently comprehensive to enable the subscriber to budget, through the prepayment plan for most of his medical expenses. It must be one that can be easily understood by the physician and his patient. It should provide for a simple claim form to be completed by the physician.

### Some Services Not Covered

"Although comprehensive to an unusual degree, the plan suggested does not provide coverage for all medical costs which may be incurred by a subscriber. There are some services rendered by physicians to their patients which are not included in the schedule of indemnity benefits, such as home and office calls and laboratory pathological services. It was felt by The Council that the cost of these services usually do not represent a financial hardship to the patient; also the indemnities for these services cannot be effectively included in an insurance contract. Consequently, indemnities for these services were not included in this suggested plan.

"The payment-in-full principle will not apply to vaginal delivery, which will be on an indemnity basis only. Payment of the balance of the physician's usual charge would be the responsibility of the subscriber. Payments would be on a payment-in-full basis for Caesarean Sections and other operative procedures associated with obstetrics. Also, the payment-in-full principle will not apply for anesthesia in vaginal delivery. Payment of the balance of the charge of the physician giving the anesthesia for vaginal delivery would be the responsibility of the subscriber. Anesthesia services in connection with Caesarean Section and other operative procedures in connection with obstetrics would be provided at the scheduled anesthesia time basis.

### Will Need Advisory Committee

"Some new experimental coverages are included in the suggested plan. In the determination of adequate payments under some of these coverages, and in instances where specific benefits are not listed, the underwriting company will require the assistance of an active Medical Advisory Committee to be established by the Ohio State Medical Association.

"The estimated monthly premium for the plan herein outlined would be approximately $2.45 for a single person contract and $7.26 for a family contract.

"This plan is in the tentative stage. It will not be adopted in final form until all segments of the profession have had an opportunity to review it and to offer comments and suggestions. After it is put into final form, each member of the Association will be given an opportunity to participate, or not to participate, according to his individual choice."

---

## Three Award Programs for 1963 Announced by Student AMA

Three award programs in the field of medical communications for medical students, interns and residents have been announced by the Student American Medical Association, 333 N. Michigan Ave., Chicago 1, Illinois.

The awards, for medical photographs and art, for scientific papers, and for scientific exhibits, consist of cash prizes, trophies and nation-wide recognition.

*To train the doctors of tomorrow, medical education needs your help today*

Give to the school of your choice through AMA-ERF

AMA-ERF

American Medical Association
Education and Research Foundation
535 N. Dearborn Street, Chicago 10, Illinois



# Warning To All Members!

★ Your Memberships in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA* (with other AMA publications), will expire on December 31. Here's how to renew them:

★ Mail your check immediately for dues to the Secretary-Treasurer of Your County Medical Society.

★ OSMA dues are $35.00. AMA membership dues for 1963 are $45.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer.

★ Many members probably will want to send one check to cover local, state and national dues. Make Check Payable To Your County Medical Society. If you do tender a separate check for AMA dues, make it payable to your County Medical Society and mark on the check the words "For 1963 AMA dues."

★ Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago.

★ Remember: As a part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal,* without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA, Today's Health, The AMA News,* and an *AMA Specialty Journal* of choice.

★ Memberships and subscriptions are on a calendar year basis. Both expire on December 31. Renewal must be made by January 1, 1963, to keep them current.

★ Members who were exempt from paying OSMA or AMA dues, or both, in 1962 will be carried over on the 1963 membership roster of both organizations on authorization of the County Medical Society secretary. This action is automatic unless the status has changed.

In Our Opinion

# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*
*— Justice Robert H. Jackson in AAA Supreme Court Case, 1942*

### AMAZING STORY ABOUT AMA TOLD IN OCTOBER 27 JAMA

Next time you hear some colleague charge that the AMA is a do-nothing outfit, suggest to him that he take the time to read the October 27, 1962, issue of *The Journal of the AMA*. It carries 130 pages of material about the AMA, ranging from information about the Los Angeles interim session to data on the activities, projects and plans of the various departments, councils, bureaus and committees of the national organization. It is an amazing report. Reading that issue should convince even the hardest boiled skeptic that the AMA is a dynamic organization and is doing one swell job not only for the medical profession but for the general public as well. How about it? Help the AMA to do a bit of horn tooting. In the end, it's your AMA. P. S. Be sure to read the October 27 issue of the *JAMA* yourself.

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### SHOUTING OVER, BUT STILL MUCH WORK TO BE DONE

We congratulate physicians generally through the state (and their wives) for the active and concrete interest they displayed during the recent political campaigns in Ohio. They got in and pitched in many areas. They made financial contributions to the party and candidates of their choice. Each will have to test his own conscience as to whether he gave adequately. Those who did not register to vote or did not vote, should feel ashamed.

But, the 1962 campaigns and election are only a phase of what has to be a 365-days, around the clock interest in political and civic affairs.

In a recent speech, John J. Joseph, vice-president for public relations and public affairs of the Ohio Bell Telephone Company, made these potent observations which apply to physicians as well as to business men:

"Businessmen must not feel content that they have satisfied their obligations by an annual monetary contribution to a political party. They can no longer abdicate and leave the fight on specific issues to the other fellow or stand aloof when temporary advantage can be gained by sacrificing principle.

"Perhaps in the final analysis the most significant question is whether business leaders have lost the essential toughness necessary to withstand the constant pressures upon them — for at stake is the question of whether our form of democracy will continue to survive or will join the other forms of human liberty that have passed into oblivion.

"And finally, let us always keep in mind that 'An army of lions led by a sheep could be defeated — by an army of sheep led by a lion.' "

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### HOLD YOUR FLU SHOTS FOR PRIORITY GROUPS

Communications Division of the AMA has asked radio stations to cease promoting influenza vaccination unless they make sure there is an adequate supply of the vaccine in the area. Apparently shortages have shown up in some communities because of the public demand.

This indicates that physicians should consider not vaccinating all patients at this time but only those in priority categories, namely: pregnant women, persons of all ages who suffer chronic debilitating diseases and personnel engaged in especially essential occupations, such as medical and health services, public safety, public utilities, transportation, education, communication fields, industries and large institutions where absenteeism is of particular concern.

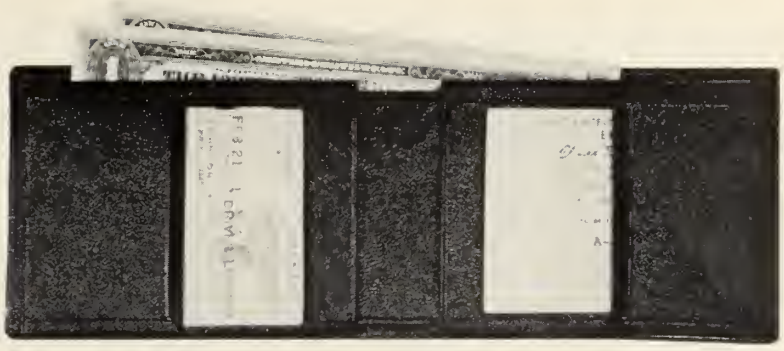
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### WHY A GRIEVANCE COMMITTEE? HERE'S ONE GOOD REASON

Why a Grievance Committee? Those who have their doubts may be convinced that it is a real public relations must for each County Medical Society after reading the following Letter to the Editor which was published in a recent issue of the *Youngstown Vindicator:*

"Editor of The Vindicator, Sir:

"In a letter to Sen. Stephen Young about the King-Anderson Bill, I informed him about a 67-year-old widow who was in the process of selling her home



*Diagnosis:* Rheumatoid arthritis

*Complication:* Pocketbook syndrome

*New therapy:* HEXADROL®

Dexamethasone 'Organon'

The corticosteroid unexcelled in clinical benefits with cost-to-patient greatly reduced

When you prescribe HEXADROL you give your patients all the clinical advantages of the newer, most effective and best-tolerated corticosteroids. At the same time, you provide relief of the Pocketbook Syndrome, a most common complication of therapy with a steroid of choice. This new and unique benefit of important savings to your patients results from Organon leadership in research, development, and new, more efficient manufacturing processes.

**Clinical background?** This steroid has a recorded history unequaled in scope and authoritativeness among all the newer corticoids. **Quality?** HEXADROL, brand of dexamethasone 'Organon'...your assurance of professional quality through research, production and control. **Dosage flexibility?** Tablets 0.75 mg. and new strength 0.5 mg., plus new form, Elixir (0.5 mg. per 5 ml.) now available to meet prescription needs.

**Cost-to-patient?** Greatly reduced! Why not check with your local pharmacist on prescription cost to your patients?

Organon

to pay for doctor and hospital bills. This letter appeared in The Vindicator and was brought to the attention of the Mahoning County Medical Society.

"The medical society asked me for information about the lady, which the children would not permit me to give them. They wanted the information to investigate and see why such a large amount of money was charged and to make some adjustment. Even without the necessary information they were able to bring about some result.

"I talked further with the people, they decided to go and see the physician first, before lodging a complaint with the medical society. After this meeting the physician and patient reached a price or explanation for the first price that was satisfactory to both.

"This result could not have been brought about without the great interest and concern of the medical society. This concern must have been evident to the physician and brought some adjustment, when the widow went to see him.

"I think that the incident shows what a great interest the physicians of Mahoning County have in the welfare of the community at large. I am sure that since we have such a fine group of physicians as this in our area a good economic-medical condition will remain in Mahoning County. If people think they have been overcharged, they should contact the Mahoning County Medical Society. I am sure that the society will find a satisfactory price adjustment or explanation for the charge."

THOMAS WELCSH."

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## BETTER BE PREPARED FOR THE BIG BAD WOLF

The customary annual tax round-up of the *Ohio State Medical Journal* appears in this issue. Read it; you'll get some helpful advice and suggestions.

What are your chances of having an income tax audit by the IRS during the ensuing year? Pretty good as you're in an income bracket where audits are made rather routinely and the nature of your "business" is such that a lot of individual auditing appears to be necessary.

What does the average internal revenue agent look for when he calls on you? Here are some of the things he concentrates on:

Your bank deposits, bank balances and your records of receipts from all sources and disbursements . . .

Your automobile expenses . . .

Expenditures for entertainment and gifts . . .

Money spent in attending medical meetings and conventions . . .

Your depreciation schedules . . .

Better have your books and statements, with supporting evidence where necessary, in apple pie order.

## OHIO RURAL HEALTH COUNCIL IS DYNAMIC ORGANIZATION

The Ohio Rural Health Council recently completed its 1962 series of seven district health conferences, held throughout the entire state and attended by more than 1,000 persons.

These conferences were sincerely appreciated by both the lay and professional persons who attended. There appears to be, throughout rural Ohio, an ever-increasing interest in the health of the individual, the family and the community. Much credit for this interest goes to the Ohio Rural Health Council, in which the OSMA is an active participant.

And, giving credit where credit is due, congratulations are also in order for all other active members of the Rural Health Council. The Agricultural Extension Service at The Ohio State University, the Ohio Farm Bureau Federation and the Ohio Department of Health deserve special commendation for their good work in this field over the years.

In our opinion, the Ohio Rural Health Council has and continues to make a significant contribution toward improving the health of rural Ohio.

---

## SOME QUOTABLE BUT UNIDENTIFIED QUOTES

- Let's hope that few, if any, elected on November 6 will fall into the category of those who are strong advocates of private enterprise so long as it is under rigid government control.

* * *

- Since health insurance plans cannot create new wealth to pay increased benefits when a fee is raised because health insurance benefits are available the insurance plan faces the danger of being priced out of the market.

* * *

- Beware of bargains in insurance. The company that significantly undersells its competitors must find a way to make up the difference.

* * *

- Advice to the physician witness: If you know what you're talking about, and if you keep your head no matter how much the attorney tries to rattle you, one cardinal principle of your own will carry you through: Be prepared.

* * *

- Most of the organization or management problems of a hospital can best be resolved by the group concerned through better communications.

* * *

- If the American people want a centralized state to relieve them of their responsibilities, and of most of their earnings, they should indicate this preference only after the moral, social and fiscal costs have been presented for their consideration.

* * *

- The average life-saving prescription doesn't cost as much as a bottle of whisky.

When you choose an anorectic—

"Does it help the patient maintain the proper diet, is it free of dangerous side effects, and does the patient like it?"[1]

Perhaps you'll find, as Stevenson did, "['Eskatrol'] seems to meet these criteria better than most."

1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



# ESKATROL® SPANSULE®

brand of sustained release capsules

PRESCRIBING INFORMATION

**Formula:** Each 'Eskatrol' *Spansule* sustained release capsule contains Dexedrine® (brand of dextro amphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the dimaleate.

**Recommended Dosage:** One 'Eskatrol' *Spansule* capsule daily, taken in the morning.

**Side Effects:** Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

**Cautions:** Clinical experience has demonstrated that 'Eskatrol' (containing the phenothiazine derivative, prochlorperazine) has a wide margin of safety and that there is little likelihood of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms). The physician should be aware, however, of their possible occurrence.

'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability.

Prescribing information adopted Jan. 1961

**Smith Kline & French Laboratories** SK&F

# Workmen's Compensation . . .

## Report on How Much Was Paid by State Agency for Medical Services to Injured Workers; Other Data

THE Ohio Bureau of Workmen's Compensation during the calendar year 1961 paid out $8,887,804.01 for medical services to injured Ohio workers, according to information provided by the Actuarial Section of the Bureau. The amount included a small sum for dental services.

Other 1961 payments, exclusive of compensation payments, included the following: $14,903,431.25 for hospital care and nursing; $160,771.54 for funeral expenses, and $59,144.60 for miscellaneous costs. With disbursements for medical expenses added, the total is $24,011,151.40.

These amounts include payments covering treatment of injured private and public employees as well as similar costs for occupational disease claims.

Comparative figures for 1960 were as follows: $8,029,808.65 for medical services to injured workers; $12,642,193.82 for hospital care and nursing; $153,362.48 for funeral expenses, and $52,779.60 for miscellaneous costs — a total of $20,878,144.55.

The number of claims filed during 1961 was 295,267 or 4.87 per cent less than in 1960.

Medical-only claims filed involving payments for physicians' services, but with no compenastion for the claimant for loss of time, numbered 223,650 for 1961, or 76 per cent of all claims filed. The average amount paid out for medical-only claims increased from $21.45 in 1960 to $22.02 in 1961.

Table 1 is a financial statement of the Ohio Insurance Fund.

Table 2 gives the 1961 awards that have been made to active claims according to the year of injury and having injury dates which in some cases reach to the beginning of the fund in 1912.

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION

as of December 31, 1961

ASSETS

| | Private | Public | P.W.R.E. | Safety & Hygiene | Total |
|---|---|---|---|---|---|
| Cash | $ 2,472,832 | $ 171,780 | $ 7,780 | $ 32,350 | $ 2,684,742 |
| Bonds | 368,112,938 | 25,536,474 | 1,167,288 | 4,802,625 | 399,619,325 |
| Premiums in Course of Collection | 46,272,613 | 8,844,502 | 81,590 | — | 55,198,705 |
| Accrued Interest | 2,750,762 | 190,824 | 8,723 | 35,888 | 2,986,197 |
| Administrative Cost Assessment | — | 32,756 | — | — | 32,756 |
| Total Assets | $419,609,145 | $34,776,336 | $1,265,381 | $4,870,863 | $460,521,725 |

LIABILITIES

| | | | | | |
|---|---|---|---|---|---|
| Reserves for Compensation and Medical | $339,329,611 | $34,363,802 | $ 358,981 | — | $374,052,394 |
| Advance Premium Deposits | 60,962,533 | — | — | — | 60,962,533 |
| Administrative Cost Assessment | 674,735 | — | — | — | 674,735 |
| Fund | — | — | — | 4,870,863 | 4,870,863 |
| Reserve for Contingencies and Surplus | 18,642,266 | 412,534 | 906,400 | — | 19,961,200 |
| Total Liabilities | $419,609,145 | $34,776,336 | $1,265,381 | $4,870,863 | $460,521,725 |

TABLE 2

Medical, Hospital, Etc., Awards Distributed to Year of Injury Occurrence

(Accident and Occupational Disease Combined)

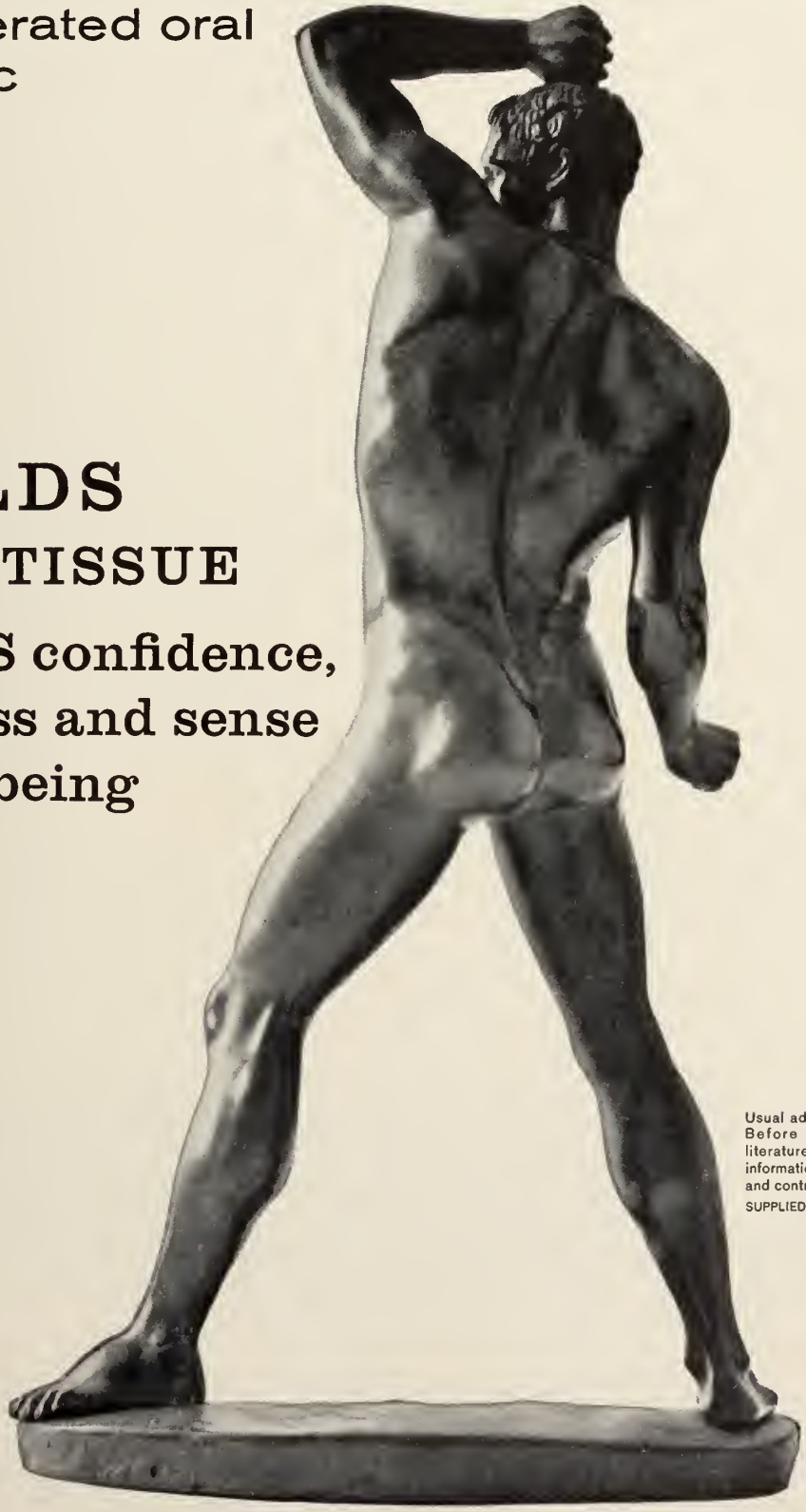
| Year of Accident or Disease | Awards | 1961 Per Cent | 1960 Per Cent |
|---|---|---|---|
| 1961 | $8,346,741 | 39 | 43 |
| 1960 | 5,439,885 | 26 | 22 |
| 1959 | 1,896,624 | 9 | 9 |
| 1958 | 937,490 | 5 | 5 |
| 1957 | 822,597 | 4 | 3 |
| 1956 | 695,594 | 3 | 3 |
| 1955 | 448,952 | 2 | 3 |
| 1954 | 442,445 | 2 | 3 |
| 1953 | 488,955 | 2 | 2 |
| 1952 | 341,092 | 2 | 1 |
| 1912-1951 | 1,373,623 | 6 | 6 |
| Total | $21,233,998 | 100 | 100 |

THE SIGNIFICANT NEW PHYSIOTONIC

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BRAND OF STANOZOLOL

well tolerated oral anabolic



## BUILDS BODY TISSUE

## BUILDS confidence, alertness and sense of well-being

Usual adult dose: 1 tablet t.i.d. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

SUPPLIED: 2 mg. tablets. Bottles of 100.

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LABORATORIES
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th WINSTROL, patients look better...feel stronger—because they are stronger

# Do You Know? . . .

Dr. Paul Orr, Perrysburg, has been given an honorary life membership by the American Association of Medical Assistants. Dr. Orr, who has been national advisor to this association for the past three years, was presented with the award at the group's annual meeting in Detroit.

* * *

Dr. Albert E. Thielen, Cincinnati, was recently installed as president of the Ohio Academy of General Practice. Dr. Thielen, chairman of the Public Relations committee of the Cincinnati Academy of Medicine, was installed during the Annual four-day meeting of the group held in Columbus.

* * *

Dr. Wilford Nusbaum, Lancaster, is the new president of the Ohio Division, Inc., American Cancer Society.

* * *

Dr. James V. Warren, professor and chairman of the Ohio State University Department of Medicine, was recently installed as president of the American Heart Association at that group's annual meeting in Cleveland.

* * *

The two doctors who headed the SOS polio prevention program in Cleveland, Dr. Howard H. Hopwood and Dr. Charles L. Leedham, were honored there recently with United Appeal awards for distinguished service.

* * *

Dr. Clifford G. Grulee, Jr., recently named Dean of the University of Cincinnati College of Medicine, has been named chairman of the directing medical staff of General Hospital by the University of Cincinnati board of trustees.

* * *

Dr. Samuel Saslaw, professor of medicine and microbiology at the Ohio State University College of Medicine, has been honored with the Army's Certificate of Appreciation for Patriotic Civilian Service. Dr. Saslaw was the first clinical physician-research investigator to undertake a contract involving use of volunteers in studying a vaccine for protection against a potential biological warfare micro-organism.

* * *

Dr. Robert R. Bartunek, Cleveland, Ohio, was chosen as President-elect of the American College of Gastroenterology at the Annual Meeting of the College, held on Sunday, October 28, 1962, in Chicago, Illinois. He will assume the Presidency at the next Annual Meeting to be held in Washington, D. C., in October of 1963. Dr. Stanley S. Sidenberg, also of Cleveland, was elected chairman of the Board of Governors.

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## Drug "Liefcort" Banned By FDA For Arthritis

Arthritis victims have been warned by the Food and Drug Administration that the drug Liefcort is extremely dangerous and has caused serious reactions including severe uterine bleeding.

The agency pointed out that the drug may not legally be imported into this country from Canada. Federal officials are halting shipments to persons who tried to obtain the drug as a result of reading an article in a national magazine last May.

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## Correction

In the November issue of *The Journal* it was erroneously stated that Stanley A. Ferguson, director of University Hospitals of Cleveland, was chosen president-elect of the American Heart Association. Mr. Ferguson was chosen president-elect of the American Hospital Association.




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A hospital for the treatment of Psychiatric Disorders. Booklet ovoiloble on request.

JOHN H. NICHOLS, M. D., *Medicol Director* G. PAULINE WELLS, R. N., *Admin. Director* HERBERT A. SIHLER, Jr., Sec'y.

MEMBER: *American Hospital Assaciatian — Natianal Assaciatian af Private Psychiatric Haspitals*

# LEPTINOL·



## *Dispel the clouds of sunset years*

Write for descriptive literature
Clinical trial samples available

Each Bi-layer tablet contains:

| | |
|---|---|
| Pentylenetetrazol . . . | 100 mg. |
| Niacin . . . . . | 50 mg. |
| Thiamine Hydrochloride | 1 mg. |
| Ascorbic Acid . . . . | 20 mg. |

Dose: One or two tablets, three times daily.

LEPTINOL is a safe central nervous stimulant. LEPTINOL is highly effective in confused states of elderly patients. Incipient psychosis of senility, with its warning symptoms of loss of interest, egocentricity, hypochondriasis, insecurity and intolerance can frequently be ameliorated.

Even in the presence of degenerative organic pathology, LEPTINOL can markedly alleviate many of the mentally disturbing symptoms.

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|---|---|---|
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| Cincinnati | The Academy of Medicine of Cincinnati<br>320 Broadway | PA 1-2345 |
| Cleveland | Cleveland Academy of Medicine<br>10525 Carnegie Ave. | CE 1-4455 |
| Columbus | Children's Hospital<br>561 S. 17th St. | CL 8-9783 |
| Dayton | Poison Information Office<br>United States Air Force Hospital<br>Wright-Patterson-Air Force Base, Ohio | TR 8-4628, Ext. 335 |
| Mansfield | Mansfield General Hospital<br>335 Glessner Ave. | LA 2-3411, Ext. 248 |
| Springfield | City Hospital<br>E. High St. and Burnett Rd. | FA 3-5531, Ext. 226 |
| Toledo | Toledo Health Department<br>635 N. Erie St. | CH 4-1961—(Day)<br>EV 5-4661—(Night) |
| Youngstown | Emergency Room Dept.<br>St. Elizabeth Hospital<br>1044 Belmont Street | RI 6-7231, Ext. 220 |


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OS-12

# Ad Astra

**Borys George Andriewsky,** M. D., Cleveland; University of Karkov, Ukraine, 1927; aged 64; died October 27; member of the Ohio State Medical Association. Dr. Andriewsky moved to Cleveland in 1957 after about five years professional work in Minneapolis and Chicago. He was in general practice. Survivors include his widow, a physician on the staff of Cleveland State Hospital.

**Austin Alphons Belai,** M. D., Hamilton; Faculty of Medicine of the University of Vienna, 1914; aged 71; died October 10; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Austria, Dr. Belai came to this country in 1939. He began practice at Millville, near Hamilton, and a few years later moved his practice to Hamilton. A member of the Catholic Church, he is survived by his widow, a sister and a half-brother.

**Robert Verne Beltz,** M. D., Montpelier; Ohio State University College of Medicine, 1943; aged 46; died October 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Beltz had been a practicing physician in Montpelier for about 11 years. Survivors include his widow, two sons, his step-mother, two step-children, and two sisters.

**Joseph Nicholas Ganim,** M. D., Cincinnati; University of Cincinnati College of Medicine, 1921; aged 65; died October 12; member of the Ohio State Medical Association, and the American Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. A native of Cincinnati, Dr. Ganim served all of his professional career there. In addition to his hospital appointments, he was associate clinical professor of medicine at the University of Cincinnati. For some time he was associated in practice with his brother, Dr. Mitchell Ganim, who survives. Other survivors include his widow, two daughters, a son, two sisters and another brother.

**Thomas Hayes George,** M. D., Monson, Mass. (formerly of Cleveland); Cleveland Pulte Medical College, 1900; aged 86; died October 6; former member of the Ohio State Medical Association and the American Medical Association. Dr. George practiced for more than half a century in Cleveland before his retirement about nine years ago. In recent years he was making his home in Massachusetts. For some 15 years Dr. George served as a member of the State Medical Board. Survivors include his widow and a son.

**Hyman Lupeson,** M. D., Cleveland; Western Reserve University School of Medicine, 1911; aged 79; died October 8; member of the Ohio State Medical Association and the American Medical Association. A native of Romania, Dr. Lupeson came to this country as a boy. He had been in the practice of medicine for more than 50 years. A member of the Temple, he is survived by his widow, two daughters, three brothers and a sister.

**Ray Marshall McCulloch,** M. D., New Concord; Ohio State University College of Medicine, 1929; aged 65; died October 15; member of the Ohio State Medical Association and the American Medical Association. A native of New Concord, Dr. McCulloch was living there since his retirement in 1961. His entire practice was at Northfield near Akron. Affiliations included memberships in the Presbyterian Church and the Masonic Lodge. Surviving are two sisters and a brother.

**Eugene Benjamin Mozes,** M. D., Canton; Royal Hungarian University Medical School, 1921; aged 65; died October 19; member of the Ohio State Medical Association and the American Medical Association. Dr. Mozes came to this country in 1923 and moved to Canton the following year. He was in private practice until his election as Stark County coroner in 1952, a post he has held since. A member of the Ohio State Coroners Association, he is survived by a sister overseas.

**Cora Jennett Randall,** M. D., Cleveland; Western Reserve University School of Medicine, 1928; aged 64; died October 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Randall, who in private life was Mrs. Ronald Sharp, practiced for some 33 years in Cleveland, specializing in pediatrics. She was associated for many years with the clinic of the Cuyahoga County Child Welfare Board. Besides her husband, she is survived by two sisters and two brothers.

**Joseph Winspear Ricker,** M. D., New Madison; Medical College of Ohio, Cincinnati, 1901; aged 82; died October 9; member of the Ohio State Medical Association and the American Medical Association. Dr. Ricker's practice extended over more than 60 years, about 30 years being in the New Madison area. He was active in civic and fraternal affairs in the community and was an honorary 33 Degree Mason. A veteran of World War I, he was a member of the American Legion. Surviving are

his widow, a son and a brother, Dr. E. G. Ricker of Monticello, Ind.

Mary Goodwin Tambling, M. D., Painesville; Cleveland College of Physicians and Surgeons, 1897; aged 99; died October 16; former member of the Ohio State Medical Association. A native of Geauga County, Dr. Tambling practiced for many years there and in Cuyahoga County. For many years she was associated in practice with her late brother, Dr. Emery M. Goodwin. At the age of 75 she went into semi-retirement, continuing her hobbies of painting and historical research. Her husband, Will Tracy Tambling, died seven years ago. Nieces and nephews survive.

Charles Carlisle Thomas, M.D., Buffalo, N. Y.; University of Buffalo School of Medicine, 1925; aged 64; died October 14. Dr. Thomas retired in September, having served as chief of staff at the Dayton Veterans Administration Center. He is survived by his widow and two sons.

Maurice Herman Weinstein, M. D., Middletown; University of Cincinnati College of Medicine, 1933; aged 56; died October 18; member of the Ohio State Medical Association and the American Medical Association. A native of Middlesboro, Ky., Dr. Weinstein began his practice in Middletown after his internship and residency training. Affiliations included membership in B'nai B'rith and the Temple. He was associated in practice with his brother, Dr. Stanley Weinstein, who survives. Other survivors include his widow, three sons, two daughters and another brother.

## Institute for Athletic Trainers Planned

At a recent meeting of the Joint Advisory Committee on Athletic Injuries of the Ohio High School Athletic Association and the Ohio State Medical Association the committee developed plans for a two-day institute for high school and college trainers. This program will be presented during the years when the postgraduate medical institute is not held. Sponsors will be the Ohio State Medical Association, the Ohio High School Athletic Association and The Ohio State University Department of Physical Education. The chairman was authorized to discuss time and program details with the chairman of the OSU Department of Physical Education and with the head trainer of the OSU Athletic Department.

At the same meeting it was decided to write a letter to presidents-elect of county medical societies suggesting that the societies emphasize locally sponsored, locally oriented athletic injury clinics for coaches in their areas during 1963, using local speakers when available.

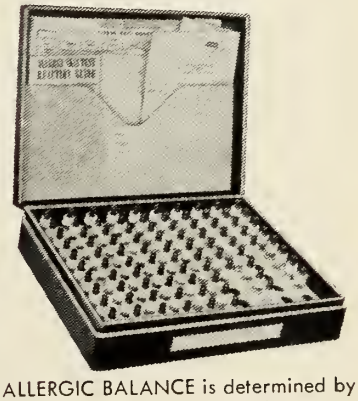
The actions above were approved by The Council of the OSMA on November 11.


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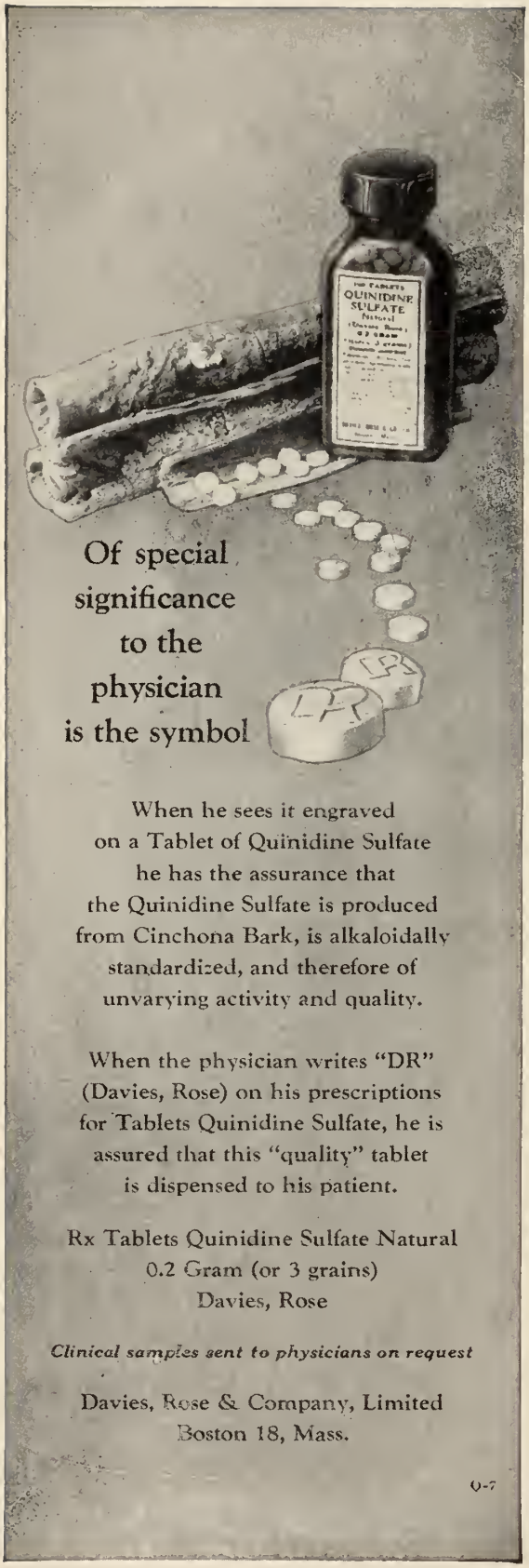
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# Buckeye News Notes...

**Alliance**—Dr. Gordan Deshler discussed "Medicare" when he addressed a recent meeting of the Alliance Knights of Columbus. Dr. Deshler reviewed the uses of the Medicare program in European countries and concluded by citing the advantages and disadvantages of such a program.

**Cincinnati**—The University of Cincinnati has been awarded a four-year $167,803 grant from the U. S. Public Health Service to support graduate training and research in UC's Kettering Laboratory Institute of Industrial Health.

**Findlay**—Dr. Charles L. Hudson, member of the Board of Trustees of the American Medical Association, was the featured speaker at a recent meeting of the Findlay Kiwanis Club. Dr. Hudson discussed "Medicine and the Federal Government."

**Lancaster**—Dr. J. L. Kraker was the speaker at a recent meeting of the Lancaster Junior Women's Club. Dr. Kraker was the spokesman for the Fairfield County Medical Society when he discussed the proposed King-Anderson Bill to provide medical aid for the aged.

**Cambridge**—The Cambridge Rotary Club recently honored one of its long time members by presenting the Rotary Merit Award to Dr. Henry L. Wells.

**Wilmington**—Wilmington College has sponsored an exhibit of art by Dr. Edmond K. Yantes, a local physician. The three-week exhibit was opened with a public reception in the Boyd Auditorium gallery on the Wilmington Campus.

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### Medical Assistants in Youngstown Area Are Guests for Dinner

One hundred and fifty-two medical assistants, secretaries and technicians were guests of their bosses at the annual Medical Assistants Dinner held by the Mahoning County Medical Society on Thursday, November 8 at the Mural Room Restaurant in Youngstown.

Following dinner, entertainment was provided by The Moderns, a jazz combo. A number of door prizes were awarded and each young lady received a jeweled pin as a favor.

Dr. S. D. Goldberg, social chairman of the Medical Society, was chairman for the dinner. Guests were: Dr. C. W. Stertzbach, president of the medical society, Mrs. Mildred Butcher, president of the Medical Assistants Society, Dr. W. B. Hardin, chairman of the Medical Assistants Committee, and Dr. A. A. Detesco, Public Relations chairman.

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Dr. Harold J. Reese, Youngstown, has been named president of the Kiwanis Club of Uptown Youngstown.

# Activities of County Societies . . .

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### HAMILTON

Miss Monica Nolan, Democrat, and Rep. Donald D. Clancy, Republican, were the featured speakers at the October meeting of the Cincinnati Academy of Medicine. The speakers appeared on a program, "The Importance of Knowing the Candidates for Public Office." Other candidates for office in the Cincinnati area were introduced.

## Second District

(COUNCILOR: GEORGE J. SCHROER, M. D., SIDNEY)

### DARKE

Dr. Albert Sarver was awarded a 50-year service pin at a recent meeting of the Darke County Medical Society. Dr. George Schroer of Sidney, OSMA Second District Councilor, presented the award to Dr. Sarver at the meeting held at the Greenville Country Club.

### MIAMI

Dr. Sam Flook, Dayton, was the featured speaker at the October meeting of the Miami County Medical Society. The dinner meeting, preceded by a social hour, was held at the Piqua Country Club.

### MONTGOMERY

Dr. Richard H. Overholt, Clinical Professor of Surgery at Tuft's University's School of Medicine and director of the Overholt Thoracic Clinic in Boston was the featured speaker at a recent meeting of the Montgomery County Medical Society. Dr. Overholt's presentation included reports on his recent work toward the development of "Surgery as a Satisfactory Treatment for Bronchial Asthma" and his recent observations concerning "Surgical Treatment of Cancer of the Lung."

## Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

### SENECA

Members of the Seneca County Medical Society met recently for a dinner-meeting at the Bel-Aire restaurant. Following the dinner and a short business session the group went to the new Betty Jane Memorial Rehabilitation Center and were given a conducted tour of the new building.

## Fourth District

(COUNCILOR: EDWIN R. MURBACH, M. D., ARCHBOLD)

### LUCAS

The November meeting of the Academy of Medicine of Toledo and Lucas County was held as a joint meeting with the Toledo Bar Association. At the medical section meeting of the Toledo Academy a local panel discussed "Case Records of Maternal Deaths in Ohio."

### OTTAWA

Dr. and Mrs. Donald Loeffler and Dr. and Mrs. Kenneth Aikins were welcomed as new members of the Ottawa County Medical Association and the Ottawa County Medical Auxiliary at a joint meeting of the groups recently. The featured speaker at the meeting was Earl Wiseman, candidate for state representative.

### SANDUSKY

The Sandusky County Medical Society has announced that it has completed three doses in its Sabin oral vaccine program with 93 per cent participation. A mobile unit was used to distribute a part of the vaccine.

## Fifth District

(COUNCILOR: HENRY A. CRAWFORD, M. D., CLEVELAND)

### ASHTABULA

Dr. Hubert R. Graves of Ashtabula was honored recently by the Ashtabula County Medical Society. A dinner at the Swallows restaurant cited Dr. Graves' 50 years of service in medicine. He was presented a certificate and award button by Dr. Henry A. Crawford, Cleveland, OSMA Fifth District Councilor.

### CUYAHOGA

The Cleveland Academy of Medicine was the cosponsor with the Cuyahoga unit of the American Cancer Society, the Cleveland Surgical Society, the Academy of General Practice, and the Cleveland Society of Obstetricians and Gynecologists in presenting its November program. At the afternoon session, a symposium was held concerning "Care of the Patient with Advanced Cancer—Chemotherapy, Psychotherapy, Religious Aspects, Treatment of Family and Special Problems." Following dinner, a talk was presented on "Home Care of the Patient with Advanced Cancer." The featured speaker at both

sessions was Dr. Robert J. Coffey, professor of surgery and chairman of the department of surgery at Georgetown University's School of Medicine.

## Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

### COLUMBIANA

A combined surgical-medical team from St. Elizabeth Hospital, Youngstown, featured the program when the Columbiana County Medical Society met recently. Dr. Edward Massullo and Dr. Angelo Riberri, surgical members of the team, described the latest techniques in artery grafts and showed a movie on the repair of heart defects.

Medical members, Dr. Leonard Caccamo and Dr. Elias Saadi, showed a film on a technique whereby physicians are able to visualize by x-ray various heart chambers and valves and the blood circulation.

### SUMMIT

A panel discussion on the topic "Hospital Relations for the Physician — Member" was the program at the November meeting of the Summit County Medical Society. Dr. Walter A. Hoyt, Jr., served as moderator of the panel.

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D. MARTINS FERRY)

### BELMONT

Dr. Milton L. McCall, professor and chairman of the department of obstetrics and gynecology at the University of Pittsburgh and medical director and chief of staff of the Elizabeth Steel Magee Hospital in Pittsburgh, will speak on "Obstetrical Complications" at the December 20 meeting of the Belmont County Medical Society.

### TUSCARAWAS

Dr. John H. Kennedy, assistant professor in charge of thoracic surgery at Western Reserve University's School of Medicine, detailed open heart surgery and showed films on an actual operation at a recent meeting of the Tuscarawas County Medical Society.

## Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, ZANESVILLE)

### FAIRFIELD

Dr. C. F. Clark, president of the Fairfield County Medical Society, has reported that the group met recently to revise the previously organized disaster




survival plan. Dr. Clark said that further details will be announced at a later date.

### WASHINGTON

The Washington County Medical Society has honored Dr. C. A. S. Williams in recognition of his 50 years of service to his profession and community. The Marietta physician and surgeon, who recently retired from active practice, has received a 50-year pin and certificate in appreciation of his long service.

## Ninth District

(COUNCILOR: CHESTER H. ALLEN, M. D., PORTSMOUTH)

### SCIOTO

A panel discussion on "Relationship between the Doctor, the Clergy, and the Patient" was presented at a recent meeting of the Scioto County Medical Society. Dr. Jerome Sheets was the moderator for the discussion.

## Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

### FRANKLIN

Dr. Albert B. Sabin, developer of the Sabin polio vaccine was the featured speaker before a joint meeting of the Academy of Medicine of Columbus and Franklin County and the Central Ohio Academy of Pharmacy recently. Dr. Sabin spoke on the subject, "Requirements for Eradication of Poliomyelitis."

### ROSS

Dr. H. William Clatworthy of Children's Hospital, Columbus, was the guest speaker at the November meeting of the Ross County Medical Society.

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

Thirty-nine members attended the October meeting of the Lorain County Medical Society held at the Oberlin Inn. Committees met at 5:30 p. m. followed by a social hour and dinner.

Dr. J. A. Cicerrella reported the final plans for the first Sabin Oral Vaccine Sunday, October 14th. It was later reported that 127,690 persons were immunized at 41 stations in the county. All moved smoothly with no delays. Over 100 physicians participated.

Dr. James T. Stephens reported on the new OSMA Medicine and Religion Committee, advising that Lorain County was one of the three counties in the state chosen for a pilot study.


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# Rules on Handling Drugs . . .

## State Pharmacy Board Adopts Requirements Governing Industrial Medical Service Centers and Nursing Homes

THE Ohio Pharmacy Board has adopted rules setting up minimum standards for retail pharmacies, hospital pharmacies or drug rooms, nursing homes, and industrial medical service centers. These rules, which have the effect of law, were adopted after they had been reviewed by various organizations, including the Ohio State Medical Association, and following a public hearing on October 22.

### Medical Set-up Rules

The rules on handling, storing and dispensing of drugs in industrial medical set-ups read as follows:

- No dangerous drugs are to be dispensed except upon the written prescription of a practitioner or the practitioner's order on the patient chart.
- The industrial first aid room must maintain a narcotic register with a perpetual inventory of narcotic drugs stocked.

### Storage of Drugs

- All dangerous drugs and narcotic drugs except those requiring refrigeration are to be kept in a safe and secure place, which is to be kept locked in the absence of the physician or the person in charge of the first aid room. This place may be a room, enclosure, or cabinet, the keys to which are to be in the possession of the physician or the person in charge of the first aid room.
- All wholesale invoices for dangerous drugs shall be kept for at least two years and shall be available for inventory by duly qualified Federal and State drug inspectors. The first aid room must be able to account for the distribution of all dangerous drugs through proper notation on the patient's medical record or by any other means.
- All purchase orders or requisitions for dangerous drugs must be signed by the industrial physician in charge of that first aid room.

### Nursing Home Rules

After listing the library and equipment requirements of nursing homes, the rules on drugs pertaining to nursing homes state:

- The stock of drugs should include such USP, NF, and other commonly used chemicals, drugs, and preparations sufficient to compound and prepare all types of ordinary prescriptions as directed by the needs of the nursing home as expressed by the requirements of the physicians in charge of the patients and residents in the home.
- The stock, library and equipment shall be housed in a suitable, well lighted and well ventilated room or department of at least 75 square feet in floor area with clean and sanitary surroundings primarily used for the compounding and preparing of prescriptions and to the manufacture of pharmaceutical preparations. The room or department should be equipped with necessary counters, table, drawers, shelves, and storage cabinets; a sink, separate from toilet facilities, with hot and cold running water.

### Dispensing Regulations

- Medicines and drugs shall be given only to the individual patient or resident for whom they are prescribed, shall be given in accordance with the directions on the prescription or the physician's orders, and shall be recorded on the patient's or resident's record.
- Every container of medicine and drugs prescribed for an individual person shall be properly and clearly labeled as to the following:

  (1) Date

  (2) Name of patient or resident

  (3) Directions for use

  (4) Name of physician

  (5) Identity of the drug and prescription number

### How To Be Stored

- All medicines and drugs except those requiring refrigeration shall be kept in locked medicine cabinets. No other materials or supplies shall be kept in medicine and drug cabinets. Keys shall be in the possession of the administrator or other person in charge in the absence of the administrator.
- Medicines and drugs for an individual patient or resident which under law may be purchased only on prescription shall, with the approval of the attending physician, be sent with the patient or resident when he leaves, or when he dies, destroyed or disposed of under the supervision of his physician.
- Narcotics shall be ordered, dispensed, administered, and disposed of in accordance with State and Federal Laws and Regulations.
- All disinfectants, pesticides, and poisons shall be kept in a locked cabinet.



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| Manganese (as Manganese Betaine Citrate) | 1.0 mg. |
| Zinc (as Zinc Betaine Citrate) | 1.25 mg. |
| Magnesium (as Magnesium Betaine Citrate) | 6.0 mg. |
| Vitamin B-1 | 1.5 mg. |
| Vitamin B-2 | 1.2 mg. |
| Vitamin B-12 | 6.0 mcg. |
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# Activities of Woman's Auxiliary...

CHAIRMAN, PUBLICITY COMMITTEE—Mrs. Rivington Fisher, 549 Eastmoor Blvd., Columbus 9, Ohio
(Roster of Officers, Page 1439)

## FRANKLIN

The Woman's Auxiliary to the Academy of Medicine of Columbus and Franklin County is playing a vital part in the Sabin Oral Polio Vaccine Immunization Program being held this fall, for the population of Columbus and Franklin County. Auxiliary members are assisting the Academy in its goal of complete immunity for the population of Columbus and Franklin County against polio.

The Sabin Oral Vaccine is being given at 118 "school stations" in the city and county. Type I vaccine was given on September 30, Type II on November 4, and Type III vaccine will be given on January 6.

Mrs. Harold I. Humphrey, Auxiliary president, represented the Auxiliary organization at a Citizen's Steering Committee meeting held on July 12 at the Fort Hayes Hotel. Thirty-six representatives of civic organizations were in attendance at this educational meeting. Mrs. Humphrey advised that the first Citizens' Steering Committee meeting outlined in detail both the medical aspects of this oral Polio Immunization Program, and the administrative problems involved in connection with the clinics at these 118 school locations.

In stressing national auxiliary priorities, the Auxiliary's committees have been busily engaged in the following activities:

The AMA-ERF committee has been selling the Foundation's Christmas greeting cards with all proceeds to be turned over to the Foundation. This is the major project at present, to be followed by various others after the first of the year. This committee has as its chairman and co-chairman Mrs. George Morrice and Mrs. Alexander Pollack.

Auxiliary's Community Service Committee with Mrs. John W. Means, chairman; and Mrs. Henry J. Wynsen, co-chairman; in recruiting Auxiliary members to assist the Tuberculosis Society again throughout the year with their testing program. A total of approximately 300 suburban public and parochial schools for 1962-63, will be included in this testing program by the Auxiliary's Community Service Committee.

The Committee on Legislation composed of Mrs. Harve Clodfelter, chairman; Mrs. R. W. Bohl, Mrs. Albert Brinz, Mrs. George Curtis, Mrs. Leonard Greentree, Mrs. Henry Lacey and Mrs. Phillip J. Reel, has been working toward election day with a campaign to get potential voters registered. Mrs. Curtis spoke of this need to get out our friends and neighbors, at the September meeting of the Auxiliary. A few moments of the October meeting were devoted to the importance of getting voters to the polls who represent the same kind of thinking we do; we have a word for it—"like-minded-voters." Mrs. Humphrey, our President, has agreed with State and National that top priority must be given to the Committee on Legislation so that they may keep us informed on pertinent legislation throughout the year. To this end, some member will be prepared to explain to the Auxiliary both legislation pending, and the voting records of our respensentatives in Congress. The committee is currently studying the Kerr-Mills and King-Anderson Bills and also the Means Test applied in Ohio welfare.

## GREENE

The Woman's Auxiliary to the Greene County Medical Society held its first meeting September 7 at The Golden Lamb in Lebanon. Mrs. Calvin Warner of Cincinnati, State president-elect, spoke on the Fall Conference "Clinic." Mrs. John Tharp, President, Mrs. Ray Barry, president-elect, Mrs. Harold Tharp, Mrs. L. W. Sontag and Mrs. R. D. Hendrickson attended the conference.

The October 5th meeting was held with luncheon at the Antioch Inn, Yellow Springs. General business was launched for the year, Mrs. John Wolff selling Christmas cards for the AMA-ERF, Mrs. Cary Gardner chairman of the candy sale for Nurses Scholarship, Mrs. R. D. Warner chairman for collection of drugs and dressings for the World Health Organization, Mrs. Gordon Savage Chairman of the Doctor's Coffee served monthly at County Society meetings.

On October 9, Mrs. John Tharp, Pres., Mrs. R. F. Kelly, Mrs. H. E. Ray, Mrs. R. D. Hendrickson and her mother, Mrs. Clark, attended the Second District meeting at the Trails End Club, Dayton. Mrs. R. F. Kelly, State Safety Chairman conducted one of the panel discussions.

## LUCAS

The Auxiliary to the Academy of Medicine of Toledo and Lucas County awarded a scholarship to Miss Edith Whitman, a freshman from the Maumee Valley Hospital School of Nursing, at the annual Health Careers Tea, October 24. Local physicians participated in the program which was a panel dis-

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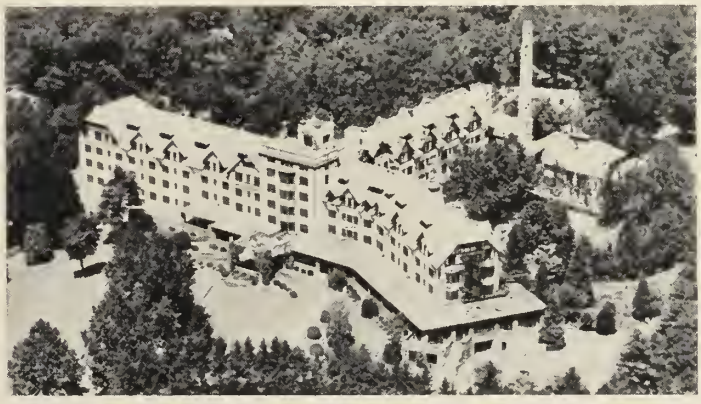
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cussion entitled "Opportunities in Health Careers." Dr. John R. Jones moderated the panel composed of Dr. Richard Baer, physiatrist; Dr. Carter Straub, radiologist; Dr. Daniel Hanson, pathologist; and Dr. Zane Skalski, dentist.

All Lucas County doctors and their wives who did not register to vote in the November election were called by the Auxiliary telephone committee and urged to do so before the registration deadline.

Members of the Academy asked the Auxiliary to provide them with hostesses for entertaining teachers at the Academy Building on BIE (Business, Industry, Education) Day, October 3.

Classes for expectant parents in the Toledo area are being held again this Fall. Registration for this series stands at 38 couples. The Woman's Auxiliary co-sponsors these classes with the Family Life Education Center of the Board of Education.

### ROSS

Mrs. Lewis Coppel, was hostess to the Auxiliary to the Ross County Medical Society at a dinner meeting September 6. Mrs. Paul MacCarter presided and announced that Mrs. Richard Counts, last year's president, had received a certificate of achievement at the State Convention.

Mrs. Edwin Artman, community service chairman, reported that the auxiliary is again recruiting helpers for the Sabin Oral immunization program. She informed the group there would be three immunization stations operating within Chillicothe and four stations in the county.

The October meeting was a dinner meeting held at the home of Mrs. David McKell. Mrs. Paul MacCarter presided at the business session and introduced Mrs. Don Aichholz, a prospective member, and Mrs. Sam Marable of Columbus, a guest.

Mrs. William Garrett, mental health chairman, reported on her visit to the State Hospital, Gallipolis. Mrs. Paul MacCarter reported on the Fall Conference she attended at Columbus, Ohio. Mrs. William Corzine and Mrs. Lowell Smith also attended the conference.

Mrs. Lewis Coppel, legislation chairman, presented the program for the October meeting. The program included thumbnail sketches of candidates for election and the showing of a movie "The Wisconsin Story."

### SCIOTO

Mrs. Edward Bauman, of Warren, president of the Woman's Auxiliary to the Ohio State Medical Association, was the honored guest and speaker at the October meeting of the Woman's Auxiliary to Scioto County Medical Society.

The monthly meeting celebrated the 22nd anniversary of the local auxiliary in the form of a birthday


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anniversary tea in the home of Mrs. William E. Daehler.

Charter members present also were honored.

Mrs. Jack D. MacDonald conducted the business meeting, at which plans for the year were presented by the committee chairmen.

Mrs. Fitch reviewed tentative plans for a medical careers evening to be held in February at McKinley Junior High School. Area guidance counselors, high school students and parents will be invited to panel and group discussions.

The organization voted unanimously to endorse the bond issue for the proposed community hospital.

Mrs. Alden B. Oakes presented a report on the fall conference of the state auxiliary, giving excerpts from speeches by Mrs. Earl Roles, national auxiliary member on the American Medical Political Action committee board of directors, and Rev. Dr. Paul McCleave, director of the department of religion and medicine of the AMA. The aim of this department is to answer better the needs of medicine and the church in providing total care of the patient.

Mrs. Jerome Rini, program chairman, introduced Mrs. Bauman, who explained national goals as related to state and local auxiliaries. She spoke of the new international health organization committee, which collects unused medical supplies and publications for distribution to countries lacking adequate medical help. Mrs. Bauman reported on activities of the American Medical Education and Research Foundation.

### SUMMIT

New members were guests of honor when board members of the Woman's Auxiliary to the Summit County Medical Society met for coffee September 11 at the home of Mrs. Duane E. Banks. Mrs. H. W. Allison presided while committee chairmen explained the auxiliary's work. Assisting with arrangements were Mesdames R. H. Gollings, H. W. Banks, S. A. Schlueter, C. J. Mader and B. F. Suffron.

"Sabin for Summit" was explained by Dr. Emmett P. Monroe, chairman of the Public Health Committee for Summit County Medical Society, and Ronald L. Williams, president of the Summit County Pharmaceutical Association, to auxiliary members and volunteers working on the Sabin program when they met for brunch. A film was shown of a similar program in Maricopa County, Arizona. Mrs. C. J. DeWinter is chairman of the "Sabin for Summit" program.

Members of Woman's Auxiliary to the Summit County Medical Society were hosts on October 23, for the Sixth District Medical Auxiliary meeting with delegates coming from Portage, Stark, Trumbull, Mahoning and Columbiana Counties.

Mrs. H. W. Allison, president of the Woman's Auxiliary to the Summit County Medical Society, introduced Mrs. Lee Ann Elliot of Chicago, who


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General Surgery, One Week, February 25
Board of Surgery Review, Part II, Two Weeks, March 4
Basic Internal Medicine, Two Weeks, March 4
Management of Common Fractures & Dislocations, One Week, December 3, February 25
Board of Internal Medicine Review, Part II, One Week, April 8
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spoke at the luncheon held at Woman's City Club. Also at the speakers' table were Mrs. Edward Bauman of Warren, president of the Woman's Auxiliary to the Ohio State Medical Association, and Mrs. J. J. McDonough, Youngstown, director of the Sixth District.

A reception was held for visiting doctors and their wives at the Sheraton-Mayflower Hotel. Dinner was served at the Akron Tower Motor Inn where Mr. Leonard E. Read, president of the Foundation for Economic Education, Inc., spoke.

VAN WERT

Dr. Richard Ireton, acting chief of surgical service at the Veterans Administration Center, Dayton, was the guest speaker for the first fall meeting of the Van Wert County Medical Auxiliary. Dr. Ireton showed slides and spoke of his experiences on the mercy ship, "Ship of Hope."

This was a guest night for doctors. The dinner meeting was held at the Peony Room of the Yours and Mine Restaurant.

During a brief business meeting, Mrs. Harold Smith, auxiliary president, announced the auxiliary had received a state certificate of award for achievement for the 1961-62 year, with Mrs. Walter Scheidt as president.

Officers for this year include Mrs. Smith; Mrs. Dale Underwood, president-elect; Mrs. Edward White, secretary-treasurer; Dr. Walter Scheidt, advisor.

## Rules on Enforcement Power Of Health Commissioner

Attorney General Mark McElroy recently gave the following opinion:

A health commissioner of a general health district, appointed under Sec. 3709.11, R. C., is authorized by Sec. 3701.56, R. C., to enforce the sanitary rules and regulations adopted by the public health council under Sec. 3701.34, R. C., and may institute criminal proceedings for violations of such sanitary rules and regulations.— Opinion No. 3343.

## Cleveland Clinic Offers Course in Surgery

The Cleveland Clinic Educational Foundation is offering a postgraduate course in surgery. This course will be presented on January 9 and 10 by staff members of the Cleveland Clinic Foundation, assisted by several guest speakers. A courtesy luncheon will be served on Wednesday and Thursday.

Due to limitation of auditorium capacity, registrations will be limited to 125. Interns and residents will be admitted without charge.

The course will be held on the fourth floor of the North Clinic Building located at Euclid Avenue and East 93rd Street.

Additional information may be obtained from Walter J. Zeiter, M. D., Director of Education, Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 6, Ohio.

## Butler County Medical Team To Work in Algeria

An emergency medical team of doctors and nurses is being formed in Butler County to leave late in December for emergency work in Algeria.

Dr. Charles U. Hauser, Hamilton, because of his previous experience in medical team work, received a request to form such a team after the provisional Algerian government requested help. Volunteers quickly responded. The final team probably will consist of eight physicians and 12 nurses. Doctors will work for a month at the Beni-Messous Hospital. Nurses will remain for three months, according to present plans.

Six similar teams have been formed in other areas for work in Algeria. Approximately 1500 doctors left Algeria when the French pulled out, leaving perhaps 500 in the entire area. Teams are organized as part of Medico, a service of CARE.

Dr. Hauser previously worked with medical teams in Nigeria, Jordan and South Viet Nam.


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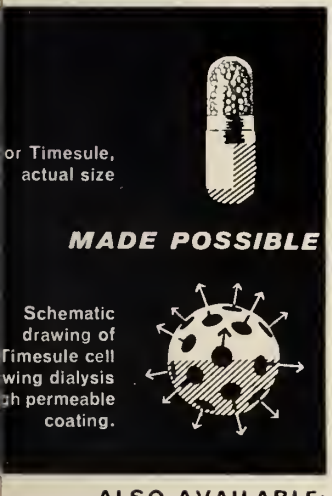
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Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

**Physicians seeking locations in Ohio** are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

ATTRACTIVE OFFICE FOR GENERAL PRACTICE with x-ray and dark room. Good hospital near by. Close to Cleveland - Akron - Youngstown. Will rent or sell outright or land lease contract. This community is planning to build a shopping center almost across the street from this office. Box 259, c/o Ohio State Medical Journal.

OFFICE SPACE FOR RENT due to death of physician. Established practice for 40 years. Ten miles to Dayton or Middletown hospitals. Community 3000 population. Will rent or lease office completely furnished with all equipment. Patients records also available. Box 236, c/o Ohio State Medical Journal.

COLORED OBSTETRICIAN or PEDIATRICIAN, Cin'ti, Ohio: Excellent opportunity in new medical center; No capital investment required; owner will remodel to suit; wood paneled waiting room, private office, receptionist area and examining rooms. Building also houses Medical Doctor, Medical Laboratory and Dentist Suites. June graduates invited to investigate. Wm. G. Menke, 2532 Indian Mound Ave., Cin'ti 12, Ohio.

APPROX. 1500 sq. ft. available for General Practitioner or Internist; long lease available at very nominal rental; ample blacktop parking; north area of Columbus; busily traveled streets; next to modern drug store. Box 271, c/o Ohio State Medical Journal.

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OB-GYN man, Residency trained — 3 years, Board eligible; Seeking Association or an area where services are needed. Available March 1963. Box 287, c/o Ohio State Medical Journal.

INDUSTRIAL PHYSICIAN for vacancy existing in Pennsylvania, Ohio, or Illinois. Full-time, starting annual salary $12,000, plus an additional $1,250 in fringe benefits. Excellent opportunity for rapid advancement. Box 292, c/o Ohio State Medical Journal.

PICKER X-RAY - FLUOROSCOPE: Tilt table; 100 MA - 100 KV with all accessories. Michael Truman, M. D., 1070 Millville Ave., Hamilton, Ohio; 895-4541 or 895-9498.

GYN - OB MAN URGENTLY NEEDED for most modern medical center building in choicest location in one of Ohio's fastest growing communities 20 minutes from Cincinnati. No investment. Full Secretarial service. Box 296, c/o Ohio State Medical Journal.

WANTED: Board-qualified or certified Otolaryngologist to associate with two Board-certified Otolaryngologists. Modern 17 room office in new building adjacent to 600 bed hospital. Salary $15,000 first year; consider partnership after first year. Age to 40. Military obligation completed. Write to V. L. Goodwin, M. D., Park Avenue Professional Building, 932 Belmont Avenue, Youngstown 4, Ohio.

GENERAL PRACTITIONER, Middle Aged for Admitting Service. Salary dependent on personal qualifications; many fringe benefits including retirement, health insurance and life insurance; paid vacation; sick leave; etc. Opportunities for professional advancement. Apply to: Hospital Director, VA Hospital, University Drive, Pittsburgh 40, Pennsylvania.

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ORTHOPAEDIC SURGEON WANTED: Well established expanding 20-man group located in excellent hospital. Board eligible or certified. Unusually high salary for two years then partnership. Excellent professional situation in 2-man department. Write Box 298, c/o Ohio State Medical Journal.

OPHTHALMOLOGIST, has modern air-conditioned brick office, apartment on rear. Cor. lot Main St., Hamilton, O. Established active residential & industrial practice. Will help interested person get established. Will lease, sell or rent. Due to family health conditions, owner leaving city. Box 299, c/o Ohio State Medical Journal.

WANTED: Eager ambitious General Practitioner interested in private practice adjacent to extremely busy practitioner who is willing to share many present and most new patients. Low rent, including heat, air conditioning and decorating. Exceptional opportunity for young physician to establish himself in an excellent lucrative location. Get a good start, be independent and yet partially associated. Western area of Cincinnati. Apply Box 302, c/o Ohio State Medical Journal.

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WANT TO SHARE OFFICE in distinguished medical building, Columbus downtown area; office is used evenings only. Will be available daytime until 5 p. m. For information, call BR 9-2856 after 8 p. m.

PHYSICIAN to assume responsibility for emergency room at Good Samaritan Hospital on temporary basis until July 1963; hours 7 to 5; salary open; must be M. D. licensed in Ohio; foreign applicant must have passed ECFMG. Apply to Sister Anna, Administrator, Good Samaritan Hospital, 1125 Fairview Ave., Dayton, Ohio; Phone 278-2612.

COMPLETE OFFICE EQUIPMENT for sale, including 1962 model hydraulic examining table and autoclave; to settle estate of physician and surgeon. Mrs. A. C. Ormond, 3205 Dresden Road, Zanesville, Ohio.

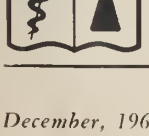
## Middle Section ENT Group To Meet in Cleveland

Cleveland will be host on January 13 - 14 to the Middle Section meeting of the American Laryngological, Rhinological and Otological Society. In charge of arrangements is Dr. Charles E. Kinney, Cleveland, vice-president for the Middle Section, one of four sections in the nation.

There will be three scientific sessions: One on Sunday from 4:00 to 6:30 p. m.; and two on Monday from 9:00 a. m. to noon and again from 2:00 to 4:00 p. m.

Even though papers will be confined to the field of otolaryngology, any member of the medical profession is welcome. Sessions will be at the Statler-Hilton Hotel.

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*References:* (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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